BUSINESS PRACTICES IN THE INDIVIDUAL HEALTH INSURANCE MARKET: TERMINATION OF COVERAGE

HEARING

BEFORE THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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BUSINESS PRACTICES IN THE INDIVIDUAL HEALTH INSURANCE MARKET: TERMINATION OF COVERAGE

THURSDAY, JULY 17, 2008

HOUSE OF REPRESENTATIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m., in room 2154, Rayburn House Office Building, Hon. Henry A. Waxman (chairman of the committee) presiding.

Present: Representatives Waxman, Murphy, Speier, Lynch, Tierney, Van Hollen, Cummings, Braley, Sarbanes, Kucinich, Davis of Virginia, Issa, Bilbray, Platts, and Shays.

Staff present: Phil Barnett, staff director and chief counsel; Kristin Amerling, general counsel; Karen Nelson, health policy director; Karen Lightfoot, communications director and senior policy advisor; Andy Schneider, chief health counsel; Roger Sherman, deputy chief counsel; John Williams, deputy chief investigative counsel; Sarah Despres, senior health counsel; Michael Gordon, senior investigative counsel; Steve Cha, professional staff member; Earley Green, chief clerk; Jen Berenholz, deputy clerk; Caren Auchman and Ella Hoffman, press assistants; Zhongrui "JR" Deng, chief information officer; Miriam Edelman, special assistant; Mitch Smiley, staff assistant; Lawrence Halloran, minority staff director; Jennifer Safavian, minority chief counsel for oversight and investigations; Keith Ausbrook, minority general counsel; Adam Fromm and Molly Boyl, minority professional staff members; Patrick Lyden, minority parliamentarian and member services coordinator; and Jill Schmaltz, minority senior professional staff member.

Chairman WAXMAN. The committee will please come to order.

I want to, as the chairman of the committee, welcome our newest member, Representative Jackie Speier, who represents the 12th District of California. We are very pleased to have her on our committee. She is very experienced as a State legislator, and I want to acknowledge the fact that she is now a member of the committee.

Today's hearing begins what I hope will be a series of hearings into how the market for individual health insurance policies work.

The individual health insurance market serves approximately 14 million Americans. Some Members of Congress cite that the individual market as a model for national health insurance reform, yet the business practices of the companies that sell individual health

insurance policies have never been closely examined by the Congress.

Today's hearing will examine a little known business practice in the individual health insurance market, which the industry calls "post-claims underwriting." Post-claims underwriting is a sanitized name for an exceptionally offensive practice, retroactively denying health insurance to people who get sick, and when they get sick.

Most Americans who have health insurance get that insurance through their employers or through government programs like Medicare or Medicaid or Tricare. Americans who are fortunate enough to have group insurance are not at risk for post-claims underwriting. Group insurance coverage can't be terminated when you need it the most.

Americans who purchase health insurance in the individual market face a very different situation. In most States, insurers require applicants for individual health insurance to fill out detailed application forms that are designed to identify any physical or mental health condition or chronic illness.

Insurers are supposed to then look at the application provided on these forms before approving the applicant for coverage. Based on this information, the insurer decides whether to issue the policy, to issue the policy with certain restrictions, such as refusing to cover pre-existing conditions, or to deny the application altogether. This process is called medical underwriting and the expectation is that it will occur before the policy is issued or denied.

Post-claims underwriting happens after the individual health insurance company has decided to approve a policy and to issue that policy. It is often triggered after the policyholder gets sick, or has an accident and requires major health insurance coverage to be put into place to pay for the bills. The insurer then goes with a fine-toothed comb through the insurance application, to see if there is any technicality that can be used to justify rescinding the policy.

This happened to two of our witnesses, Heidi and Keith Bleazard. They will tell us how their health insurance was taken away after Heidi suffered serious injuries in a biking accident. Their insurer, Regence, claimed that Heidi and Keith made a mistake in their application for health insurance, and then the insurance company terminated the policy. They were left with more than $100,000 in medical bills.

What happened to the Bleazards is inexcusable. The reason families buy insurance is so that they will be covered when they get sick. But Regence canceled their insurance when they needed it the most.

Unfortunately, the experience of the Bleazards is not an isolated one. We will hear today that over 1,000 individuals in California had their insurance policies inappropriately rescinded. And we will hear about policyholders in Connecticut who suffered the same thing. One person who was terminated because the insurer said he should have known that his occasional headaches would later be diagnosed as Multiple Sclerosis.

I understand that insurance companies need to protect themselves from fraud. But that is not what happened in California, Connecticut, or across the country. Insurers are using technicalities, or trumped-up "misrepresentations," to rescind policies after

policyholders get sick and accumulate hundreds of thousands of dollars in medical bills.

Now, that may be a great deal for the insurance companies. They can pocket the premiums while the families are well and then cancel the coverage if anyone in the family get seriously sick. But it defeats the whole point of getting an insurance policy in the first place.

While State regulators are the front line of defense for consumers, the Federal Government is the last line. Under HIPAA, the Federal Health Insurance Portability and Accountability Act of 1996, consumers are guaranteed the right to renew their individual health insurance policies unless they have defrauded the insurer or intentionally misrepresented their medical condition.

Unfortunately, few consumers know of their Federal HIPAA rights to guaranteed renewability. That is because the Federal agency responsible for enforcing HIPAA, the Centers for Medicare and Medicaid Services, has done nothing to enforce those rights or to ensure that States do so. Of its 4,387 full-time employees, only 4 are assigned to administering HIPAA. CMS has never taken any action against any health insurer for post-claims underwriting that violates a consumer's HIPAA rights.

Our hearing today will examine how the practice of post-claims underwriting is being abused to deny coverage to ailing Americans. We will learn what some State regulators are doing to stop the abuses.

And we will ask why the Federal Government is doing nothing to protect consumers from this practice.

And we will ask the health insurance industry's trade association why insurers in the individual market do post-claims underwriting, and why it has taken the intervention of regulators to bring an end to this unfair practice in some States.

These are not academic questions. Discussions are already underway about how the next Congress might best ensure that all Americans have adequate health care coverage. Some health care reform proposals would move millions of Americans, including many of those now insured through their employers, and billions of Federal dollars, into the health insurance market.

This would obviously be a radical change in our health care system. Whether it represents reform is a debate for another day. To prepare for that debate, however, we all need a much better understanding of the individual health insurance market as it currently functions. The purpose of this hearing is to begin that educational process.

And I now want to recognize Mr. Issa for an opening statement.

[The prepared statement of Chairman Henry A. Waxman follows:]

Opening Statement of Rep. Henry A. Waxman
Chairman, Committee on Oversight and Government Reform
Business Practices in the Individual Health Insurance Market:
Terminations of Coverage
July 17, 2008

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While state regulators are the front line of defense for consumers, the federal government is the last line. Under HIPAA — the federal Health Insurance Portability and Accountability Act of 1996 — consumers are guaranteed the right to renew their individual health insurance policies unless they have defrauded the insurer or intentionally misrepresented their medical condition.

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Mr. ISSA. Thank you, Mr. Chairman.

Mr. Chairman, I would like to have unanimous consent for principles for insuring fair and appropriate practices for individual market policy rescissions and pre-existing conditions causes entered into the record at this time.

Chairman WAXMAN. Without objection, that will be the order.

[The information referred to follows:]

Principles for Ensuring Fair and Appropriate Practices for Individual Market Policy Rescissions and Pre-existing Conditions Clauses

The Board of Directors of America's Health Insurance Plans (AHIP) and its member plans are strongly committed to ensuring appropriate, consumercentric practices in the individual insurance market. We are committed to allowing clear and reliable processes in the rare case where an insurance policy is withdrawn or "rescinded" and for the application of preexisting conditions clauses. When a health insurance plan makes these decisions we support appropriate consumer protections and appeals of these decisions.

Accordingly, health plans need to make the processes for rescissions and for the application of pre-existing conditions clauses clear to consumers. These processes need to be fair, balancing the rights and responsibilities of the health plan, the rights and responsibilities of the consumer, and the rights of the other individuals insured by the health plan.

The purpose of this Appendix is to provide guidance to consumers and health insurance plans regarding their respective rights and responsibilities when inaccurate information is discovered on an application for comprehensive, major-medical-type health insurance and when a health plan makes a decision based on information in such an application.

APPLICATIONS: CONSUMER RIGHTS AND RESPONSIBILITIES
Consumers have the right to apply for individual policy coverage and the responsibility to meet certain requirements when doing so:

1. Consumers should have knowledge of their medical information when applying for a policy. Before completing the application, consumers should review their medical history and should confer, as needed, with any treating physician or other health care provider to ensure that their information is accurate and complete.

2. Consumers should contact the health plan if they have any questions about the information or directions in any materials received from the health plan or from a sales representative.

3. Consumers should take personal responsibility for providing complete

and accurate answers to application questions and, as part of the application process, should sign a statement that they have reviewed all of the information provided. Consumers should *not* assume that the health insurance plan will contact any health care providers identified in the application for additional information.

4. If consumers are in doubt about whether certain information does or does not need to be provided in response to an application question, they should either (1) provide such information on the application, or (2) contact the health plan to ask whether to include the information.

5. Consumers should carefully review and verify all information in the application submitted to the health plan.

APPLICATIONS: HEALTH INSURANCE PLAN RIGHTS AND RESPONSIBILITIES

Health insurance plans have the right to develop plan-specific procedures governing applications, which may differ from plan to plan based on the insurer's internal structure, state law requirements, or other factors. However, all health plans have the responsibility to incorporate the following principles in their insurance application processes:

1. Insurance application questions should be clear and understandable.

2. The application should include a clear statement that information disclosed on the application will be relied upon by the health plan to make a coverage decision. The application should also include clear notification to the consumer of the consumer's responsibility to provide complete and accurate answers, and that failure to do so may result in rescission of the policy.

3. The health plan should provide the consumer with a reasonable opportunity to review the answers to application questions in order to ensure that the answers submitted are complete and accurate, and should provide a toll-free phone number and internet address to assist consumers seeking additional information.

4. Sales representatives and other health plan personnel responsible for providing information and directions to applicants should be trained to instruct applicants to provide complete and accurate answers to all questions on the application, and to take the time necessary to ensure

comprehensiveness and accuracy. Health plans should provide a special toll-free phone number and internet address for questions, comments, or other consumer feedback regarding the accuracy and/or adequacy of information or directions provided by such personnel.

5. In reviewing an application, the health plan should identify any apparently inadequate, unclear, or otherwise questionable information on the application prior to issuing a policy, and should be responsible for obtaining clarification from the consumer prior to issuing a policy.

6. The health plan should rely on written underwriting standards that govern the risk undertaken by the health plan at the time of the application, and should be willing to disclose the reason for an underwriting action to consumers upon request.

RESCISSION AND PRE-EXISTING CONDITIONS EXCLUSION DECISIONS: CONSUMER RIGHTS AND RESPONSIBILITIES

In the event that a health insurance plan seeks to review a policy for rescission or acts to rescind coverage, the consumer should have the right to challenge the rescission, subject to the following responsibilities:

1. Consumers should be responsible for promptly responding to inquiries regarding medical and personal information requested by the health plan during a rescission investigation or review of a claim denial based on a pre-existing medical condition.

2. Consumers should be responsible for following the health plan's procedures for internal appeals and external reviews.

RESCISSION AND PRE-EXISTING CONDITIONS EXCLUSION DECISIONS: HEALTH INSURANCE PLAN RIGHTS AND RESPONSIBILITIES

Health plans have the right to develop and implement plan-specific policies and processes for rescissions and pre-existing conditions exclusions, based on the plan's internal structure, state-law requirements, or other factors, and should incorporate the following principles:

1. The health plan should conduct an objective and thorough investigation prior to initiating a rescission and when reviewing a claim denial based on an exclusion for a pre-existing medical condition.

2. The health plan should limit rescission actions to those based only on

information that should have been included in a complete and accurate response to questions asked in the application. If the health plan failed to conduct a thorough review of unclear or questionable information from the application process, and, based on that review, failed to seek additional information from the applicant, information subsequently obtained by the health plan may not be used as the basis for rescinding coverage.

3. The health plan should limit application of pre-existing conditions exclusions and, if the health plan issues a policy that would otherwise provide benefits for the condition, should provide coverage for a medical condition that is disclosed by an applicant during the application process, unless the condition is the subject of a rider. A health plan could continue to apply current state requirements for pre-existing condition exclusion periods to non-HIPAA eligible individuals who do not provide accurate and complete information about their medical conditions during the application process.

4. The health plan should undertake a rescission investigation within a reasonable time after obtaining the information prompting the need for an investigation; should make reasonable efforts to obtain, in a timely manner, any additional information needed to complete the investigation; and should complete the investigation within a reasonable time after receipt of or efforts to obtain any necessary additional information. The health plan may not rescind a policy while an investigation is in progress.

5. If a health plan, following an investigation, determines that grounds for rescission exist, the plan should:
• notify the customer of the information that has been obtained;
• explain the specific reasons why coverage may be rescinded;
• provide a reasonable time period for the customer to respond with additional information;
• provide clear instructions on how to submit such information; and
• keep the customer apprised of delays because of difficulties in obtaining information.

The plan should promptly review such information, if submitted, and should advise the customer regarding the plan's decision to maintain the

policy as issued, reissue the policy subject to revised terms, or proceed with rescission.

6. The health plan's decision to rescind a policy should be based on reliable evidence and should be consistent with the criteria used to initially underwrite the policy. The information on which the health plan seeks to rescind coverage must be material to the risk undertaken by the health plan at the time the policy was underwritten. For example, information about a health condition or treatment arising subsequent to the issuance of the policy may not be used as the basis for, or considered relevant to, a proposed rescission.

7. Health plans should have a full, fair, and clearly stated internal appeal process, and should clearly inform customers of their right to access the process if they wish to dispute a rescission or a claim denial based on a pre-existing medical condition. The process should, at a minimum, include an opportunity to appeal to reviewer(s) distinct from the initial decision maker, and should include review by a medical professional, as appropriate.

RESCISSION AND PRE-EXISTING CONDITIONS EXCLUSION DECISIONS: THIRD PARTY REVIEW OF MEDICAL ISSUES

Health plans should provide consumers with access to a third-party review process to resolve disputes involving medical issues related to pre-existing condition exclusion and rescission decisions.

The third party review process should be established through state legislation that incorporates the following principles:

1. State regulators would screen requests to determine if they are eligible for review (e.g. is there a medical issue in dispute).

2. The third-party reviewer would be independent from both the health plan and the consumer.

3. The review process would include specified timeframes for completing the review, with expedited review available for emergency situations, and would be governed by standards that promote consistency in the decision-making process.

4. The review panel would consist of at least one medical professional and

one attorney.

5. Exhaustion of internal appeal processes before initiation of third-party review and exhaustion of third-party review processes before initiation of litigation would be required.

6. An external review decision favorable to the consumer would be binding on the health plan.

7. If the third-party reviewer upholds the health plan's decision, punitive damages would not be available in any subsequent litigation.

8. In any subsequent litigation, the decision of the third-party review entity would be presumed to be correct and the burden of proof would be on the plaintiff to demonstrate otherwise.

9. If a health plan's decision to rescind a policy is upheld in a third-party review, then the individual would be eligible for coverage in a state guarantee access plan.

Mr. ISSA. Thank you, Mr. Chairman.

Mr. Chairman, getting individual insurance can be difficult in a market place. The market place clearly favors risks allocated or apportioned over large groups. Losing individual coverage retroactively can put one's life at risk. I believe that is the reason for this hearing today.

I think it is an incredibly important reason for the Bleazards who are here today, and we will get the pronunciation better as we go on, I am sure. You have our deepest sympathy. Clearly, mistakes happen. Wrongdoing can occur. And we are here today to try to separate both of those from the legitimate practice of looking for fraud in applications.

Undoubtedly, I am sure you will agree in testimony that all three exist. People make mistakes. People defraud insurance companies. And insurance companies make mistakes, or use practices in some cases that are clearly wrong and self-serving. So, I appreciate the committee covering this.

Although HIPAA's jurisdiction is extremely limited, and the administration of both President Clinton and now President Bush have seen fit to see little or no Federal wrongdoing. That doesn't stop this committee from seeing whether in fact two administrations have been wrong and perhaps create an opportunity for the next administration to get it right.

Certainly, our witnesses today from California and Connecticut will be very helpful. It is very clear that although people who are victims, or alleged victims, of misconduct by health insurance carriers are important to hear from. It is also important to hear from as many people who are advocates or responsible for administering the fair use of these opportunities on both sides. Only State regulators have primary jurisdiction. Their goal, the goal of the people of California, Connecticut, and all of our States, is, in fact, to guarantee consumers the contract sanctity necessary in health care arrangement.

Consumers clearly need more access and more awareness to this growing problem that an individual health care application could, in fact, retroactively be denied. It is not uncommon when people are filling out applications for people quite harmlessly to gloss over or not take time to mention that they had an injury or an illness decades earlier. That clearly should not allow a technical and unrelated cancellation to occur.

We have an industry in America that is under considerable assault with rising costs and limited ability for individuals or even companies to pay. I join with the chairman in recognizing that with 44 plus million uninsured Americans, the last thing we need to do is to have people doubting whether it is worthwhile to get insurance to begin with.

Very clearly, unless people can count on contract sanctity, it is likely that we would only increase the number of people who choose to put the money into a savings account or spend it rather than make that investment against the rainy day occurrence of an illness or injury.

Mr. Chairman, as we talked earlier, at this time I would like to ask unanimous consent to have our witness from the third panel, so closely related to the industry and to the regulators, Stephanie

Kanwit, be allowed to be on the first panel, because we believe that it is the only way to have a fair back and forth during the evaluation. And it will save a considerable amount of time.

Chairman WAXMAN. This suggestion that you are making and requesting by unanimous consent is one that we have discussed. And as we looked at how to organize this hearing, we think we have organized it in a way that is fair to everyone and will give everyone an opportunity to speak. We could put everybody on one panel, but CMS didn't what to be on with the State regulators, which might have made some sense. The insurance companies' trade association, are going to be on afterwards. I don't see why they have to be on this panel. We have always tried to accommodate the minority and staff in witness recommendations and in structuring the hearings, but our best judgment is we have structured it the way that it makes the most sense.

Mr. ISSA. Mr. Chairman, since the UC has not agreed to, and since the minority disagrees at this time that this is by any means fairness, and since there is obviously a slanting on the first two panels by the majority and our one witness has been relegated to the last panel, I would hereby make a motion that we move Stephanie Kanwit to the first panel at this time.

Chairman WAXMAN. Is your witness the insurance company? Is that why you are here, to protect the insurance company? Why don't we hear about this problem? And also, as Californians why don't we hear from the California regulators, who I think we ought to be proud of for having done the right thing. They represent the Republican Governor. Let's hear from the witnesses and not go through a procedural motion.

I would urge the gentleman not to try to pursue a motion to rearrange the committee hearing list. I understand your point. You have made a point. But it is the prerogative of the chairman to decide the order of the witnesses, and we always welcome input. And, in fact, I think we have been more responsive to the input from the minority than when we were in the minority.

Mr. ISSA. Well, Mr. Chairman, we did talk about the other alternative, which would be to have the State regulators, including California, who is considering some of these reforms that the association representative will be talking about on the same panel, and you also declined that. So, at this time, I must reiterate my motion to combine the third and first panel.

Chairman WAXMAN. I don't know whether it is appropriate even to entertain such a motion. Let me have our counsel review that and advise me. I have never in my 34 years in the Congress ever had a Member, or seen a Member, make a motion to stop a hearing for witnesses by asking that they be rearranged in different panels, or in different positions. I have never seen it. It is a first time. I think it is quite inappropriate because we are trying to get the witnesses the opportunity to be heard. Members of the committee have not been informed that there may be motions before us today. This is a hearing and not a committee meeting. I will recess for a second and consult my counsel.

Mr. ISSA. Thank you, Mr. Chairman.

[Recess.]

Chairman WAXMAN. The Chair will recognize himself in opposition to this motion. I think it is quite outrageous to make a motion on the basis that the insurance company is unable to make their case because they are the last ones to speak. I think what we need is to have an opportunity to hear all of the witnesses. And it is the prerogative of the Chair to make this determination. I think we have acted fairly. And so, I would urge Members to vote against the motion.

Mr. ISSA. Speaking in favor of it, Mr. Chairman, and I will be brief. Insurers, and their representatives, trade association, have answers to many of the questions. Regulators have questions to be answered. The banter between the two was not a hypothetical request, but, in fact, one that I believe very strongly would promote a better dialog.

The prerogative of the Chair under the House rules and the committee rules is relatively limited. The ability of the majority to, by vote, do what they want to do is pretty absolute. Today, we make this request mostly because, in fact, your party said that you wanted to come together. Our party did lose the last election. We want to work with you. This is not an adversarial hearing. And, it should not become one.

This is a hearing in which we are trying to find ways to fix a real problem. We have real people here who were adversely affected by it. The regulators that are here today are here with hypothetical and proposed answers in order to keep this from happening in the future, and they will in many cases need legislation and perhaps Federal help to do so. The insurance association representative that we chose to have here, we want them to be answerable for this practice and we want them to be part of any solution. That is necessary in our free market.

Mr. Chairman, you did mention that you thought that the motion was not in order. I might remind you that when you were in the minority, you made motions for subpoenas, or threatened to make motions for subpoenas at hearings like this. This is an opportunity, a scheduled opportunity. We were all given notice that, in fact, a hearing and subjects related to the hearing may very well be brought up.

Mr. Chairman, I very much believe that we should look to redo this panel to make it more equitable and more effective. I am happy to work with you on any compromise, but I don't believe that we were properly recognized in the process of finding an acceptable panel that would be beneficial to all of the individuals who are going to spend their time on the day as here, and for those individuals and representatives who are here today to give testimony and be questioned.

Chairman WAXMAN. The gentleman has made his case. The issue before us is a motion to rearrange the panels. All those in favor of the motion offered by the gentleman from California, Mr. Issa, will say aye.

Mr. ISSA. Aye.

Chairman WAXMAN. All those opposed will say, no.

[A chorus of noes.]

Chairman WAXMAN. The noes have it, and the motion is not agreed to.

Mr. ISSA. Mr. Chairman, on that, I have to ask for the nays and ayes.

Chairman WAXMAN. All those in favor of the ayes and nays raise your hand.

[A show of hands.]

Chairman WAXMAN. An insufficient number and the request for a roll call is not granted.

Mr. ISSA. Mr. Chairman, I appeal the ruling of the Chair.

Chairman WAXMAN. You would go that far to keep us from even hearing these witnesses because you are worried that we won't be here to hear the insurance company? Well, we won't even get to the insurance company if you drag out this hearing.

Mr. ISSA. Mr. Chairman, I do not want to drag out the hearing. I will at this time——

Chairman WAXMAN. Those in favor of overruling the decision of the Chair will say aye.

Mr. ISSA. Aye.

Chairman WAXMAN. Those opposed will say no.

[A chorus of noes.]

Chairman WAXMAN. The noes have it.

Mr. ISSA. Mr. Chairman, on that, I ask for the ayes and nays.

Chairman WAXMAN. All those in favor of a roll call vote, raise your hand.

[A show of hands.]

Chairman WAXMAN. An insufficient number. The request is not granted.

Now we will hear from our witnesses. The committee will receive testimony from Heidi and Keith Bleazard, who are from Logan, UT. They had their health insurance policy retroactively rescinded by Regence Blue Cross and Blue Shield, of Utah, after Heidi was in a serious biking accident. They will explain the circumstances and consequences surrounding the rescission of their insurance coverage.

Dale Bonner is secretary of the Business, Transportation and Housing Agency for the State of California. Mr. Bonner was appointed by Governor Arnold Schwarzenegger in March 2007, and oversees 13 departments, including the Department of Managed Health Care. He will testify about the actions his agency has taken to help consumers who had their health insurance inappropriately rescinded.

Cindy Ehnes, the director of the Department of Managed Health Care, was initially listed as a witness, but she was unable to appear this morning, because she is in negotiations with two remaining large plans, Anthem Blue Cross and Blue Shield of California, on this issue.

Mr. Bonner is accompanied today by Amy Dobberteen, chief of Enforcement Division of the Department of Managed Health Care.

And Kevin Lembo heads the Office of the Healthcare Advocate for the State of Connecticut in his role as Connecticut's lead advocate for patients and their families. Mr. Lembo will discuss Connecticut's experience with health insurance rescissions and what steps Connecticut has taken to aid policyholders and prevent future rescissions.

It is the policy of this committee that all witnesses that testify before us do so under oath. So I would like to ask all of you, if you would, to please stand and raise your right hands.

[Witnesses sworn.]

Chairman WAXMAN. Thank you. The record will indicate that each of the witnesses answered in the affirmative.

Mr. Bleazard, why don't we start with you and your wife, and have you speak to us. There is a button on the base of the mic, which you have to push in to turn the mic on, and we want to welcome you to the committee and express our appreciation for your willingness to be here.

STATEMENTS OF HEIDI BLEAZARD, LOGAN, UT; DALE E. BONNER, SECRETARY, CALIFORNIA BUSINESS, TRANSPORTATION AND HOUSING AGENCY, ACCOMPANIED BY AMY DOBBERTEEN, CHIEF OF ENFORCEMENT DIVISION, DEPARTMENT OF MANAGED HEALTH CARE; AND KEVIN P. LEMBO, MPA, STATE HEALTHCARE ADVOCATE, CONNECTICUT

STATEMENT OF HEIDI BLEAZARD

Ms. BLEAZARD. Hello, my name is Heidi Bleazard.

Chairman WAXMAN. The button on the mic needs to be pressed, and pull it closer so that we can hear you.

Ms. BLEAZARD. Can you hear me? My name is Heidi Bleazard, and I am here with my husband, Keith Bleazard to testify about the problems we had with Regence Blue Cross and Blue Shield of Utah rescinding our health insurance coverage.

In February 2005, Keith and I decided we wanted to get an individual health insurance policy for ourselves. We had two friends who are insurance agents, Doug Thatcher and Troy DeLair. Keith had known them for over 10 years. We met with them a few times, and filled out applications for health and life insurance, and a nurse came out to complete more detailed paperwork. On one of the forms Keith marked that he had a history of back trouble, but wasn't sure what to write in the comment section on the back. We consulted with Doug who knew all about Keith's back history having similar difficulties with his own back.

Over the years and quite recently, they discussed and compared their similarities, including medicines and doctor visits. After discussing Keith's back, Doug Thatcher, one of our agents, wrote in the application that Keith had "slipped disc in back, had surgery 1996, full recovery." Doug assured us the paperwork was filled out satisfactorily, and we trusted his knowledge of what information the insurance company needed.

Keith had surgery in 1996 for a herniated disk and went 3 years without any pain or trouble of any kind. Later Keith pulled his back playing basketball and developed back pain that his Doctor helped him control with medicine. He has since then carried on his normal active life, including his job in floor covering, involving hard physical labor, a wide variety of rigorous activities such as hockey, snowmobiling, and being an active member of a Search and Rescue team.

The medicine and doctor visits were detailed by the nurse on another form. We thought all the forms were being used together

with our medical records, which we signed a release for the insurance companies to use to make their decisions. We received a letter in March 2005 from Regence, indicating that our application had been accepted and we had health insurance coverage.

On August 18, 2005, I was in a bad mountain biking accident. I broke my neck in two places and my back in five, had a pulmonary contusion, a few broken ribs, and a brain injury. Search and Rescue got me to where I could be life flied to a trauma center, and they placed me in an intensive care unit. I had to have several hours of neurosurgery on my spine. When I got out of the hospital, I had to stay in a rehabilitation unit until I was good enough to go home. My medical bills were over $100,000.

In November, just when the scope of the bills was becoming apparent, Regence notified us they would be looking into our medical records. And then in January 2006, Regence notified Keith and I that they were rescinding our health insurance policy retroactively. They claimed that Keith failed to provide information in the application about his back. Regence did not respond to our attempt to talk with them to find out where the misunderstanding came from.

Troy DeLair, the senior agent, also attempted to clear things up with Regence, communicating to them we had no intention of misleading them. Regence had accepted the claims and paid for Keith's medicines and doctor visits without any problem for most of a year. Having signed the release of records at the time of our application, and being open to the agents and the nurse, we had no reason to suspect Regence was missing any information. Only after the bills from my accident were mounting did they notify us of a problem.

Later we learned that they had not received the nurses report detailing Keith's pain medicines and doctor visits, and went to life insurance only, and that these things should have been included on the form that Doug had helped us fill out. Had Regence returned a copy of our application with our healthcare policy, as prescribed by law, at the time of our acceptance, we would have had the opportunity to question where the rest of the paperwork was, and perhaps avoid the future confusion.

I hope insurance companies such as Regence would be prohibited from rescinding insurance coverage without making a thorough inquiry into the facts and circumstances surrounding the application of the insurance. In our situation it was completely inadequate to simply look at the application and compare it to Keith's medical records. Had Regence understood all of the facts, I do not believe they would have felt it was appropriate to retroactively cancel our coverage.

And I thank you for the opportunity to appear before this committee to provide information about our circumstances. Keith and I are hard working, responsible citizens. We have never had any trouble with our creditors before this time, or with the law. I believe that Regence has taken advantage of the situation to avoid paying the large medical bills for my biking accident. Any help that you can provide in making sure that these unethical practices do not continue in the future would be most appreciated.

[The prepared statement of Ms. Bleazard follows:]

United States House of Representatives
Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, DC 20515-6143

Testimony of Heidi Bleazard
Provided to the United States House of Representatives
Committee on Oversight and Government Reform
July 17, 2008

My name is Heidi Bleazard. My husband, Keith, and I reside at Logan, Utah. Keith and I have a blended family. I have nine children and Keith has five children. Some of my children are now grown, and we have one granddaughter.

I am here to testify about the problems I had with Regence, Blue Cross and Blue Shield of Utah rescinding my health insurance coverage.

In February of 2005, Keith and I decided we wanted to obtain an individual policy of health insurance for ourselves. We had two friends who were health insurance agents, Doug Thatcher and Troy DeLair. We met with them a few times, and filled out applications for health and life insurance, and a nurse came out to complete more detailed paperwork. On one of the forms Keith marked that he had a history of back trouble, but wasn't sure what to write in the comment section on the back. We consulted with Doug who had a complete knowledge of Keith's back history having similar difficulties with his own back, and having discussed and compared those similarities including medicines and doctor visits over time. After discussing that issue, Doug Thatcher, one of our agents, wrote in the application that Keith had "slipped disc in back, had surgery 1996, full recovery" on the application form. Doug assured us the paperwork was filled out satisfactorily and we trusted his knowledge of what information the insurance company needed.

Keith had back surgery in 1996 for a herniated disk and went three years without any pain or trouble of any kind. Later Keith pulled his back playing basketball and developed back pain that his Doctor helped him control with medicine. He has since carried on his normal active life including his job in floor covering – involving rigorous physical labor, and a wide variety of physically rigorous activities such as hockey, snowmobiling, and being an active member of a Search and Rescue team.

The medicine and doctor visits were detailed by the nurse on another form. We thought all the forms were being used together by the insurance companies as well as our medical records, which we signed a release for them to use, to make their decisions.

Our agent submitted the application to Regence and we received a letter in March of 2005 from Regence indicating that our application had been accepted and we had health insurance coverage.

On August 18, 2005, I was involved in a serious mountain biking accident. I broke my neck in two places and my back in five. The C-2 fracture in my neck was called a "hangmans" fracture, a complete break in the neck from over extension. My physicians told me that the fracture is so severe, many individuals die as a result of it. The fractures in my back were "impact fractures", which shatter the bone at the point of greatest impact. I also had a pulmonary contusion, three broken ribs, and a brain injury. Several hours of neurosurgery were performed to save my spine. I spent three weeks in the hospital and a physical rehabilitation unit, and I am continuing to do physical therapy. My medical bills are over $100,000.00.

In November of 2005, when the medical bills were reaching a peak, Regence notified us they would be looking into our medical records. Then in a letter dated January 17, 2006,

Regence notified Keith and I that they were rescinding our health insurance policy retroactively. They claimed that Keith failed to provide information in the application about his medical history relating to his back. Regence did not respond to our attempts to talk with them to find out where the misunderstanding came from.

Regence had accepted the claims and paid for Keith`s medicine and Doctor visits without any problem for most of a year. Having signed the release of records at the time of our application, and being open with the agents and the nurse, we had no reason to suspect Regence was missing any information. Only after the bills from my accident were mounting did they notify us of a problem.

Later we learned they had not received the nurses report detailing Keith`s pain medicine and doctor visits, and that these things should have been included on the form Doug helped us fill out.

Regence did not try to talk to either me or our agents before they rescinded the policy. If they had, we would have told Regence that our agent and the nurse knew all of Keith's medical history including the fact that he took pain medication for his back. We would have told Regence that the insurance agents filled in the language on the application explaining Keith's back condition. We would have informed them that the agents had assured us that the information on the application was sufficient to explain Keith's condition. We had no intention of misleading Regence to any degree on our application.

Had Regence returned a copy of our application with our healthcare policy as prescribed by law, at the time of our acceptance, we would have had the opportunity to question where the rest of the paperwork was and perhaps avoid the future confusion. A copy of the policy and our

application would have also given us a reference to use for questions later.

As a result of Regence's improper retroactive cancellation of our policy, Keith and I have been extraordinarily concerned about how we would pay the medical bills that I have incurred. We have incurred expense to hire an attorney and we have spent significant time and energy dealing directly with health care providers.

I am anxious to see insurance companies such as Regence be prohibited from rescinding insurance coverage without making a thorough inquiry into the facts and circumstances surrounding the application of the insurance. In our situation it was completely inadequate to simply look at the application and compare it to Keith's medical records. Had Regence understood that Keith's back condition was completely disclosed by us to Regence's own agent before the time the application was filled out and that the agents themselves wrote the information in on the application, I do not believe Regence would have felt that it was appropriate to retroactively cancel our coverage.

I appreciate very much the opportunity to appear before this committee to provide information about our circumstances. Keith and I are working hard to provide for our children and to live as responsible citizens. We have never had any trouble with creditors or with the law at any time before. We are honest, hard-working people who are simply trying to make ends meet. I believe that Regence has taken advantage of this situation to get out of paying the large medical bills that are associated with my biking accident. Any help that you can provide in making sure that this type of abuse of people who receive health insurance does not happen in the future would be most welcome for Keith and me.

Dated this _____ date of July 2008

Heidi Bleazard

Chairman WAXMAN. Thank you very much. Mr. Bleazard, did you have anything to add, or is that it for both of you?

Mr. BLEAZARD. No, that was pretty much what we had prepared as far as the outline of our rescission.

Chairman WAXMAN. OK. At least you are here, and when we get to questions, you may want to respond to them.

Mr. Bonner.

STATEMENT OF DALE BONNER

Mr. BONNER. Thank you, Mr. Chairman, and members of the committee. I am Dale Bonner, secretary of California's Business, Transportation and Housing Agency. Some years ago, I was the HMO regulator in the State of California, and now as secretary, I oversee the Department of Managed Health Care, and a number of other regulatory departments.

With me is Amy Dobberteen, chief of the Department's Enforcement Division. And she will be happy to answer any specific questions that you may have about the law or specific enforcement actions. We appreciate the opportunity to be here this morning to help shed light on what you, in your opening comment, noted is a very troubling practice occurring in California, and we are sure across the Nation.

By way of background, we started getting aggressive in this area in 2006, when we saw a number of complaints, consumer complaints and an increase in litigation. And so, the Department initiated what has probably been the largest investigation of this practice in the Nation, looking at the five largest plans that provide the most individual coverage in California. That would be Anthem Blue Cross, Blue Shield of California, Kaiser, PacifiCare and Health Net.

And we think that since we started getting involved, we have seen dramatic changes in industry practices. We have seen about an 81 percent drop in rescissions just in the first year alone. And we have continued to focus on the area because, as it was noted earlier, this is a particularly harsh practice that affects individuals because unlike having your insurance policy canceled, which just means that you have no coverage going forward, in this case rescission results in the entire withdrawal of your coverage even going back. And so, it leaves the member in many cases in limbo relative to existing or ongoing treatment, and also, at risk of being, in some cases, bankrupt, as a result of substantial legal bills going back in time.

And so, we have continued to focus on these practices intensely. We don't deny that health plans have the right and, in fact, the responsibility to take a look and try to police inaccurate statements in applications and to make sure that everything is appropriate. But we have been concerned about what appeared to us to be little or no consistency in their processes or procedures for investigating these issues and medical history in determining whether to rescind coverage.

The Department's investigations and actions to date have included a total of about $3.1 million in fines, and we have brought about a number of procedural changes in health plan practices, and we have achieved a significant roll-back in a number of rescissions.

Working with our State attorney general and Department of Insurance, we have been able to work with the industry in making sure that insurance applications are much more transparent, and that everyone has a much more clear understanding of what is required in the up-front review process.

A final point, or a couple of final points, one is that in April of this year, the Department announced that we were going to take the issue a little bit further and actually go back and review each and every individual case that was, in fact, rescinded dating back to 2004. And that announcement prompted a number of the plans to come forward and offer settlements. And we achieved successful settlements with Kaiser, Health Net and PacifiCare.

And those settlements specify that the previously rescinded enrollees will be guaranteed coverage. The pre-rescission out-of-pocket medical expenses will be reimbursed or paid by the Plan, and additional compensatory damages can be gained in arbitration or private litigation, if the member so desires. Unfortunately, there are two of the major Plans that we have yet to achieve some settlement with to date. That is Anthem Blue Cross and Blue Shield of California. Together they have about 2,200 cases of rescission between them. And if we are not able to achieve settlements in those cases, then we will go forward and review each and every case. And, of course, we would prefer not to have that result. But if we are not successful, there could be very substantial fines that would be imposed against each of those Plans.

But in summary, we think our aggressive action in California has achieved significant improvements in the industry, certainly in the State, and maybe in other States, because we have brought an end to this very unfair and illegal practice. We have been assured that consumers have a much better understanding of what is required on the application at the point of intake. We have been very successful in restoring coverage for a substantial number of enrollees who have had their coverage unfairly rescinded in the middle of care. We think it is a good thing that we have been able to avoid lengthy litigation between consumers and health plans. And more importantly, we have restored some measure of faith in the individual market, so that those who go out and buy individual coverage have some greater sense of assurance that the coverage will not be rescinded at an inopportune time.

On the policy front, the Governor has signed legislation that prohibits insurance companies from trying to recoup payments from providers after they have already approved or authorized a course of treatment and then subsequently rescinded care. He also wants to outline the practice of offering bonuses or financial incentives, to claims adjusters and others, to incentivize rescinding coverage. And ultimately, the Governor wants to see a guaranteed issue in California, coupled with an individual mandate, because we feel very strongly that would eliminate the need for medical underwriting altogether in the individual market.

In the meantime, we are going to continue to vigorously enforce the existing law. And we are going to continue to look out for the interests of consumers, so that we cannot only bring light to this issue but more importantly bring an end to this very troubling practice.

Thank you.
[The prepared statement of Mr. Bonner follows:]

Dale E. Bonner, Secretary
California Business, Transportation and Housing Agency

Testimony before the
Congress of the United States
House of Representatives
Committee on Oversight and Government Reform

July 17, 2008

Mr. Chairman and Committee Members:

My name is Dale Bonner and I am the Secretary of the California Business, Transportation and Housing Agency, which oversees the California Department of Managed Health Care (Department), responsible for regulating the 107 managed care plans that operate in California. The Department is the only stand-alone state agency in the nation with the responsibility for sole oversight of HMOs, touching the lives of nearly 21 million Californians.

Thank you for inviting me to attend this hearing to talk about the actions taken by the Department to combat the improper rescissions of health care coverage. With me today is Amy Dobberteen, Chief of the Department's Enforcement Division. She is here to help answer any questions concerning enforcement actions.

In early 2006, the Department began the largest investigation of wrongful rescissions ever undertaken in the nation. These investigations of the five largest plans in California offering individual coverage -- Anthem Blue Cross, Blue Shield of California, Kaiser, PacifiCare and Health Net -- were conducted through the Department's Division of Plan Surveys, and have resulted in coordinated enforcement actions to shine a light on and bring an end to the improper use of rescission.

The Department proactively began these investigations after receiving numerous consumer complaints and learning of private class action litigation against Kaiser Permanente and Anthem Blue Cross.

These efforts have been extremely successful, and have changed industry practice in terms of underwriting processes and better consumer disclosure. As a result of the Department's aggressive oversight and enforcement actions, the number of rescissions in California dropped 81 percent the first year.

I will begin by briefly explaining what rescission is and why it is so devastating to those who experience it.

In California, there are two types of insurance – group, and individual.

Group health care coverage is provided through employers or large groups, and health plans base these premium rates on a large diverse group of people, knowing that the many who are relatively healthy will offset the cost of providing coverage to those who are not. Pre-existing conditions or state of health are not factors in who receives coverage. However, in California and elsewhere, laws protect access to coverage and rates paid by smaller groups of up to 50 employees.

Individual health coverage is for those who do not have access to group insurance, often those who are self-employed or who are employed by small businesses. Individual coverage is subject to medical underwriting – a process that allows an insurer to select which applicants it will cover, based on information supplied by the applicant on an extensive medical history questionnaire. Applicants can be denied coverage altogether or be subject to higher premiums if they have in the past been treated for ailments as minor as acne, allergies, or ringworm. Only individual insurance is subject to rescission, because it is issued based on medical underwriting.

Rescission is a harsh practice and differs from cancellation of coverage in one important way. While cancellation of coverage leaves the individual without coverage going forward, the claims incurred to date are paid. Rescission, on the other hand, is a legal remedy that treats the coverage as never having been approved in the first place. It completely wipes out a person's history of ever having coverage at all and holds the enrollee liable for all medical expenses that were paid by the plan since the issuance of the policy. It renders a person both uninsured, often in the middle of care, as well as uninsurable in the future. In addition, an entire family's coverage may be wiped out, based upon the presumed guilt of the primary enrollee.

Proper uses for rescission do exist. Health plans have the right under current California law to use rescission as a method of stopping fraud on the part of enrollees who have misrepresented their health histories in order to obtain coverage. Health plans understandably assert that they must be able to police their risk pools from fraud in order to keep premiums affordable for the entire group. Because of the potential for consumer misrepresentation on the application, it can sometimes be difficult for plans to determine whether a misrepresentation or omission was the result of fraud or inadvertence.

The problem with rescission arises when a plan engages in post-claims underwriting, which is prohibited under California's Knox-Keene Act, and defined as reevaluating the risk or underwriting *after* a claim is filed, which can lead to rescission of coverage. Current law states *that "the insurer must either complete medical underwriting up front OR show that the enrollee willfully omitted or misrepresented information on the application."*

It became apparent during the Department's investigations that all the plans followed little or no consistent processes when investigating the medical history of the applicant or in determining whether to rescind coverage. In numerous instances, plans did not investigate obvious questions about an enrollee's health history on an application, nor did they take reasonable steps to complete underwriting before issuing coverage. But they rescinded the coverage anyway, with limited recourse for the enrollee.

One of the things that is most troubling is that these actions are usually taken because enrollees are using health services. As a result, when they are rescinded, it can seriously disrupt a course of treatment and negatively affect the person's health, as well as exposing their families to large unexpected financial risks that could result in bankruptcy. In addition, it severely erodes faith in the individual market among consumers and their providers who already treated them in good faith because the health plan had authorized the treatment.

The Department's investigations and actions, including a total of $3.175 million in fines to date, as well as required process changes, have played a large role in the reduction in rescissions. Working in conjunction with the California Attorney General to ensure that enrollees are properly notified of how to exercise their rights as well as collaborating with the California Department of Insurance, the Department was able to bring about changes in applications that make it easier for applicants to understand, and to require fair processes for investigation of rescissions that include the right to appeal. Because of the Department's investigation, most of the plans in California voluntarily began changing their processes, including improving their internal policies and procedures to provide a fair process for consumers.

In addition, in April of this year, the Department announced that it would review each and every rescission case from the five plans dating back to 2004. This announcement prompted negotiations leading to settlements with three health plans so far: Kaiser Permanente, Health Net, and PacifiCare.

The settlements specify that:

- All previously rescinded enrollees of the three plans will be offered guaranteed issue coverage.
- Individuals will get coverage quickly, and it will be permanent and not subject to potential legal challenges.
- Pre-rescission out-of-pocket medical expenses will be paid by the plan.

- Consumers will get a convenient, no-cost opportunity to recover any additional damages without having to go through lengthy, costly, or uncertain legal battles.

Unfortunately, the Department has not yet reached a similar settlement with Anthem Blue Cross or Blue Shield of California. As a result, the Department will conduct an immediate review of all of their rescission cases to determine whether they applied the correct legal standard to justify the rescission. If violations have occurred, the Department will order the coverage restored and apply the appropriate fines. Given the 2,177 cases involved, these fines could very well be the largest the Department has ever assessed.

With these actions, the Department has achieved what it set out to do:

- Changed the national landscape to stop the unfair and illegal practice of rescission by holding plans accountable.
- Made sure that health plans are fair and consumers understand what is being asked of them on health history applications.
- Jumped in to restore coverage as broadly as possible for patients unfairly rescinded in the middle of care.
- Avoided lengthy court battles for individuals seeking monetary reimbursement from the plans.
- Restored confidence in the individual market.

Governor Schwarzenegger has already signed legislation making it illegal for health plans to re-collect or offset future payments for services that they already authorized on behalf of rescinded patient. The Governor will also be working with our legislature this year to outlaw bonuses or economic incentives to health plan employees for rescinding patient coverage, and to provide stronger consumer protections, such as standardizing the application process, improving consumer notification requirements, and allowing independent review panels to decide whether a rescission of coverage is appropriate.

In the longer term, the Governor wants to render these practices unnecessary by instituting guaranteed issuance of individual coverage coupled with an individual mandate.

The California Department of Managed Health Care will continue to vigorously enforce the law for the benefit of consumers and will continue to send a strong message that illegal rescissions will not be tolerated.

Appendix 1
Summary of DMHC Enforcement Actions and Case Summaries

The Department's Office of Enforcement and Division of Plan Surveys has proactively investigated rescission of individual health care coverage since early 2006 after receiving numerous consumer complaints and learning of private class action litigation against Kaiser Foundation Health Plan and Blue Cross of California. The Department has completed or pending surveys of all plans offering individual underwritten health care coverage[1] and its Office of Enforcement has taken the following actions:

In September 2006, the Department filed an Accusation against Blue Cross and assessed a $200,000 penalty for wrongful rescission, in violation of section 1389.3, because Blue Cross failed to complete pre-enrollment medical underwriting and rescinded an enrollee based on a condition she disclosed before Blue Cross approved coverage for her and some members of her family. Blue Cross is contesting the Accusation, but the matter is not yet scheduled for hearing.

On October 6, 2006, the Department ordered Kaiser to reinstate a member who had been covered under a Kaiser group-plan for 20 years. During that time Kaiser treated her for arm and neck pain and filled her prescriptions through its pharmacies. Thus, it was on notice of her arm and neck condition at the time she applied for individual coverage. Nevertheless, Kaiser rescinded the member's coverage because she did not disclose her neck and arm pain even though the enrollee reasonably believed Kaiser was aware of the condition. The member also had a congenital kidney disease and contacted the Department at a time when she was uninsured and believed she would need emergency care for the kidney condition. Because Kaiser was on notice of the member's arm and neck pain at the time it approved her application, the Department ordered Kaiser to reinstate her coverage to allow her to obtain medically necessary services for her kidney condition.

On December 13, 2006, the Department and Kaiser entered into a Letter of Agreement to settle a wrongful rescission case where Kaiser rescinded a member for failing to disclose signs and symptoms of epilepsy when the member had never been formally diagnosed. Kaiser contested liability in the case but agreed to pay a $100,000 penalty to settle the matter.

On March 1, 2007, Kaiser and the Department entered into a second Letter of Agreement wherein Kaiser agreed to pay $225,000 for a wrongful rescission where an internal data input error caused the wrongful rescission of the member's coverage. The member disclosed several pre-existing conditions and a Kaiser employee omitted a disclosure of kidney stones. It was this initial defect in Kaiser's underwriting process that led to wrongful rescission of the enrollee's coverage. As a result, Kaiser failed to properly

[1] The Department's Division of Plan Surveys conducted Non-Routine Medical Surveys of Blue Cross of California, Blue Shield of California, Kaiser Foundation Health Plan, Health Net of California, and PacifiCare.

complete medical underwriting and also failed to prove that the member willfully misrepresented his health history before rescinding coverage in violation of section 1389.3 of the Knox-Keene Act.

In May of 2006, the Department initiated its first Non-Routine Medical Survey of Blue Cross of California. The survey team reviewed 90 files of rescinded enrollees and found various deficiencies including Blue Cross's failure to properly investigate whether the enrollees it rescinded willfully misrepresented their health history to obtain health care coverage in violation of Health and Safety Code, section 1389. The Department is now undertaking a review of all rescinded cases during the survey period.

In November 2007, the Department entered into a Consent Agreement with Health Net of California after it learned that Health Net had deliberately misrepresented the existence of an employee bonus and incentive plan that was directly tied to the number of rescinded health care contracts and the resulting cost savings to Health Net. The Department took immediate enforcement action and entered into a Consent Agreement wherein Health Net agreed to pay a $1 million penalty.

Appendix 2

Summary of DMHC Fine Against Health Net

The Department assessed and collected a $1 million penalty from Health Net of California, for failing to appropriately disclose the existence of Health Net's bonus and incentive plan for employees in its underwriting Department. Representatives of the Department's survey team twice inquired of Health Net representatives, in connection with a non-routine survey assessing plan practices regarding rescission, whether any compensation, bonuses, or incentives for employees in its underwriting Department were tied to either the number of rescissions completed or cost savings to Health Net arising from rescissions. Health Net representatives affirmatively represented to the survey team that no such bonus or incentive programs existed, and claimed that bonuses and compensation incentives were awarded based solely on (1) Health Net's overall financial performance, and (2) job performance.

Only after an Order was obtained in a private arbitration case requiring Health Net to produce public employee performance evaluations, compensation and bonus structure, and press coverage was imminent, did Health Net reveal that its Senior Risk Analyst's compensation and bonus structure were tied to meeting or exceeding annual quotas and goals for rescinding health care coverage and the overall cost savings to Health Net resulting from those rescissions, and that she received a portion of her annual bonus for pursuing rescission of health care contracts.

Appendix 3
Summary of DMHC Settlement Agreements

Health Net Reinstatement Agreement Summary

Summary of Sanctioned Conduct

- The Plan did not consistently follow its medical underwriting policies, procedures and guidelines before issuing health insurance contracts.

- Because the Plan did not implement nor consistently follow policies, procedures and underwriting guidelines to ensure that it completed medical underwriting before issuing health insurance contracts, the Plan was required to show or demonstrate that the applicant willfully misrepresented health history on the applicant form before making a determination to rescind the applicant's health coverage. The Plan did not consistently show (document) that it applied the willful misrepresentation standard to its rescission determinations.

Benefits to Former Enrollees

- Plan will not rescind any coverage issued prior to May 15, 2008.

- Within 45 days, Plan will begin contacting former enrollees to extend coverage without any medical underwriting conditions. The offer will be open for 90 days.

- Enrollee may pursue any additional legal remedies.

- For those not contacted directly by the plan, the offer of coverage will be extended, if requested by the individual, until December 31, 2008.

- Any medical charges incurred by the former enrollee during the time they had prior Health Net coverage will either be forgiven or refunded.

- Three Expedited Dispute Resolution Options are offered. Arbitration decisions are final:
    - Negotiate claims directly with Health Net – submit a written claim for damages supported by documentation. Plan will settle or dispute within 60 days. If disputed, claimant may pursue other available options.
    - Claims less than $25,000 may be resolved through expedited proceeding conducted by a JAMS arbitrator on the basis of a written record.
    - Claims more than $25,000 or which include claims for damages other than paid out-of-pocket medical expenses may be resolved through binding arbitration administered by JAMS.

Benefits to Initial (Specified) Enrollees

- The initial enrollees will be offered immediate coverage without any medical underwriting conditions.
- Any medical charges incurred by the initial enrollee during the time they had prior coverage to the present will be offered by the Plan in the form of a financial settlement.
- If the financial settlement is disputed, the amount will be decided by an independent third-party review on an expedited basis, but the Plan cannot defend its rescission determination.
- If the enrollee accepts the independent arbitration award, it will be final and no additional remedies can be sought.

Requirements and Penalties for the Health Plan

- Coverage starting now no matter the health status of enrollee.
- Plan will pay all medical claims decided through independent arbitration.
- Plan will pay all claims submitted by newly-covered enrollees.
- Plan will pay an administrative fine of $300,000 upfront and $3 million within one year if it does not complete corrective actions.

Corrective Action

- Corrective actions will be completed by the Plan within 120 calendar days of the DMHC's written approval of the proposal. Corrective actions should include:
  - Clear and understandable applications, including health history questionnaires.
  - Reasonable look-back time periods on health histories.
  - Review of health history prior to issue coverage.
  - Verifying accuracy of health history statements, taking into consideration language barriers and statements from brokers and agents.
  - Notification to applicant if a Plan investigation is taking place.
  - Any rescission determination is considered by staff independent of original underwriting process.
  - An impartial grievance and appeal process.

- . As noted above, if the Plan does not substantially and implement the corrective actions within one year, the Plan will pay an additional administrative fine of $3 million.

- On or before December 31, 2008, the DMHC will conduct a follow-up survey to determine compliance with corrective actions.

PacifiCare Health Coverage Reinstatement Agreement Summary
Summary of Sanctioned Conduct

- The Plan did not consistently follow its medical underwriting policies, procedures and guidelines before issuing health insurance contracts.

- Because the Plan did not implement nor consistently follow policies, procedures and underwriting guidelines to ensure that it completed medical underwriting before issuing health insurance contracts, the Plan was required to show or demonstrate that the applicant willfully misrepresented health history on the applicant form before making a determination to rescind the applicant's health coverage. The Plan did not consistently show (document) that it applied the willful misrepresentation standard to its rescission determinations.

Benefits to Former Enrollees

- Offer arbitration concurrently for any cancellation or rescission contracts issued before June 11, 2008.

- Within 45 days, Plan will begin contacting former enrollees to extend coverage without any medical underwriting conditions. The offer will be open for 90 days.

- Enrollee may pursue any additional legal remedies.

- For those not contacted directly by the plan, the offer of coverage will be extended, if requested by the individual, until December 31, 2008.

- Any medical charges incurred by the former enrollee during the time they had prior PacifiCare coverage is not at issue due to Plan's cancellation policy.

- Three Expedited Dispute Resolution Options are offered. Arbitration decisions are final:
    1. Negotiate claims directly with PacifiCare – submit a written claim for damages supported by documentation. Plan will settle or dispute within 60 days. If disputed, claimant may pursue Options 2 or 3.
    2. Claims less than $25,000 may be resolved through expedited proceeding conducted by a JAMS arbitrator on the basis of a written record.
    3. Claims more than $25,000 or which include claims for damages other than paid out-of-pocket medical expenses may be resolved through binding arbitration administered by JAMS.

Benefits to Initial (Specified) Enrollees

- The initial enrollees will be offered immediate coverage without any medical underwriting conditions.
- Any medical charges incurred by the initial enrollee during the gap period to the present will be offered by the Plan in the form of a financial settlement.
- If the financial settlement is disputed, the amount will be decided by an independent third-party review on an expedited basis, but the Plan cannot defend its rescission determination.
- If the enrollee accepts the independent arbitration award, it will be final and no additional remedies can be sought.

Requirements and Penalties for the Health Plan

- Coverage starting now no matter the health status of enrollee.
- Plan will pay all medical claims decided through independent arbitration.
- Plan will pay an administrative fine of $50,000 upfront and up to $500,000 if it does not complete corrective actions as confirmed through a follow-up medical survey scheduled within the next 18 months.

Corrective Action

- Corrective actions will be completed by the Plan within 120 calendar days of the DMHC's written approval of the proposal. Corrective actions should include:
  - Clear and understandable applications, including health history questionnaires.
  - Reasonable look-back time periods on health histories.
  - Review of health history prior to issue coverage.
  - Verifying accuracy of health history statements, taking into consideration language barriers and statements from brokers and agents.
  - Notification to applicant if a Plan investigation is taking place.
  - Any rescission determination is considered by staff independent of original underwriting process.
  - An impartial grievance and appeal process.
- If the Plan does not substantially implement the corrective actions, confirmed within the next 18 months, the Plan will pay an additional administrative fine of up to $500,000.

Kaiser Reinstatement Agreement Summary

Summary of Sanctioned Conduct

- The Plan did not consistently follow its medical underwriting policies, procedures and guidelines before issuing health insurance contracts.

- Because the Plan did not implement nor consistently follow policies, procedures and underwriting guidelines to ensure that it completed medical underwriting before issuing health insurance contracts, the Plan was required to show or demonstrate that the applicant willfully misrepresented health history on the applicant form before making a determination to rescind the applicant's health coverage. The Plan did not consistently show (document) that it applied the willful misrepresentation standard to its rescission determinations.

Benefits to Former Enrollees

- Plan will not rescind any coverage issued prior to May 15, 2008.

- Within 45 days, Plan will begin contacting former enrollees to extend coverage without any medical underwriting conditions. The offer will be open for 90 days.

- Enrollee may pursue any additional legal remedies.

- For those not contacted directly by the plan, the offer of coverage will be extended, if requested by the individual, until December 31, 2008.

- Any medical charges incurred by the former enrollee during the time they had prior Kaiser coverage will either be forgiven or refunded.

- Three Expedited Dispute Resolution Options are offered. Arbitration decisions are final:
  - Negotiate claims directly with Kaiser – submit a written claim for damages supported by documentation. Plan will settle or dispute within 60 days. If disputed, claimant may pursue other available options.
  - Claims less than $15,000 may be resolved through expedited proceeding conducted by a JAMS arbitrator on the basis of a written record.
  - Claims more than $15,000 or which include claims for damages other than paid out-of-pocket medical expenses may be resolved through binding arbitration administered by JAMS.

Benefits to Initial (Specified) Enrollees

- The initial enrollees will be offered immediate coverage without any medical underwriting conditions.

- Any medical charges incurred by the initial enrollee during the time they had prior coverage to the present will be offered by the Plan in the form of a financial settlement.

- If the financial settlement is disputed, the amount will be decided by an independent third-party review on an expedited basis, but the Plan cannot defend its rescission determination.

- If the enrollee accepts the independent arbitration award, it will be final and no additional remedies can be sought.

Requirements and Penalties for the Health Plan

- Coverage starting now no matter the health status of enrollee.

- Plan will pay all medical claims decided through independent arbitration.

- Plan will pay all claims submitted by newly-covered enrollees.

- Plan will pay an administrative fine of $300,000 upfront and $3 million within one year if it does not complete corrective actions.

Corrective Action

- Corrective actions will be completed by the Plan within 120 calendar days of the DMHC's written approval of the proposal. Corrective actions should include:
  - Clear and understandable applications, including health history questionnaires.
  - Reasonable look-back time periods on health histories
  - Review of health history prior to issue coverage.
  - Verifying accuracy of health history statements, taking into consideration language barriers and statements from brokers and agents.
  - Notification to applicant if a Plan investigation is taking place.
  - Any rescission determination is considered by staff independent of original underwriting process.
  - An impartial grievance and appeal process.

- As noted above, if the Plan does not substantially and implement the corrective actions within one year, the Plan will pay an additional administrative fine of $3 million.

- On or before December 31, 2008, the DMHC will conduct a follow-up survey to determine compliance with corrective actions.

Chairman WAXMAN. Thank you very much. And Ms. Dobberteen, are you here for questions?

Ms. DOBBERTEEN. I am here for questions.

Chairman WAXMAN. Mr. Lembo.

STATEMENT OF KEVIN LEMBO

Mr. LEMBO. Thank you, Mr. Chairman. My name is Kevin Lembo. I am the State healthcare advocate in Connecticut. Connecticut has a unique set-up in that we have an insurance regulator in our insurance department, and I am the full-time advocate for those consumers.

On behalf of the growing number of Americans who find themselves trying to get and keep coverage in the individual health insurance market, thank you for your willingness to shed light on this very important issue.

The problem with post-claims underwriting abuse and policy rescissions appears to be growing.

Mr. LYNCH. Mr. Chairman, can we have the witness speak into the mic. I cannot hear. I am sorry.

Mr. LEMBO. The result of this process and the particularly egregious result is the unjust rescission, cancellation, or limitation of health insurance contracts after someone is diagnosed with an illness and faced with expensive medical care.

In Connecticut, we were fortunate and identified this problem in our market beginning in 2003. My office, the Office of our Attorney General Richard Blumenthal and our State Insurance Department saw a jump in complaints from consumers whose policies were rescinded or limited in some other way. They were sick, and didn't understand why their coverage was taken away or limited. Ultimately, a coordinated and successful effort by our offices was undertaken to fix the problem through legislation.

Connecticut's law, an act concerning post-claims underwriting, is the product of 3 years of work at the legislature to protect consumers from unfair health insurance rescissions, cancellations or limitations. Under the Connecticut statute, insurers now need to seek the approval of the Connecticut Insurance Department before they can rescind, limit, or cancel a policy.

I want to be clear at the outset that this public policy debate is not about consumers who intentionally misrepresent their health status. That is a red herring that is utilized as a distraction by those who would rather not have this conversation. Further, we could spend a day arguing about what motivates the desperate, albeit infrequent, action to lie on an application. Instead, I am focusing on those whose policies were unjustifiably rescinded, canceled or limited by a carrier to avoid paying claims.

In Connecticut, a company denied claims for a resident named Maria, who was diagnosed with non-Hodgkin's lymphoma in 2005. The insurer said Maria should have sought treatment and found out the diagnosis sooner, in other words, before seeking a policy.

Once the company started receiving her medical claims, it found out she had gone to the doctor for what she thought was a pinched nerve. She also told the doctor she had been feeling a little tired. Maria said she wasn't concerned about the way she was feeling because she had been working particularly hard. Tests were done at

that time to determine whether there were other issues. These tests did not yield significant results, and they were not tests for cancer. The company denied payment for subsequent, cancer-related bills, saying that Maria had this condition before she bought the policy and should have sought treatment. Maria ultimately died from her illness.

A young man, named Frank, was taken by surprise when his insurance was rescinded because his insurer alleged that he omitted material information from his insurance application. When Frank applied for coverage, he disclosed that he had occasional headaches. After he applied, the carrier obtained all of Frank's medical records, theoretically for medical underwriting, and then wrote him a policy. Several months after getting the policy, Frank went for a routine eye exam and was referred to a neurologist by that eye doctor. The neurologist diagnosed Frank with Multiple Sclerosis.

Immediately following that diagnosis, the carrier rescinded the policy stating, in effect, that he should have known his headaches would have led to a diagnosis of MS. The carrier stuck to its position even after receiving a letter from Frank's doctor saying that there would have been no reason at all to suspect MS, since Frank was an otherwise healthy young man with a normal exam. Frank was now responsible for more than $30,000 in care that he could not afford. His condition rapidly deteriorated, forcing him to end his employment, and seek public insurance and assistance.

These are the kinds of people who are impacted by post-claims underwriting abuses, and that impact is medically and financially devastating.

Unfortunately, while State Insurance Departments can often intercede in these cases through market conduct examinations under their existing laws against unfair insurance practices, there is little that can be done as regulators to make it right for these consumers, at least completely. As State regulatory agencies, they can fix problems going forward, making it safe for future consumers, but are limited in what they can do now, for these relatively uninsurable consumers who are back in the marketplace.

States need to stop this problem on the front-end with good, clear law that prohibits these abuses and forces companies to seek permission before rescinding a policy. The practice must be stopped on the front-end, because the clean-up is almost impossible.

In Connecticut, the Insurance Department recently concluded a very long and deep investigation of Assurant Companies, in particular, Time Insurance, formerly Fortis, and John Alden, that resulted in a record fine for Connecticut of $2.1 million in fine, and more than $900,00 in restitution to consumers. The Department did all they could, but the damage to the individuals, in fact, was done. Although the company admitted no wrong-doing, they agreed to pay the fine and restitution.

Mr. Chairman, it is my opinion, and that of many of my colleagues, that our States need to move rapidly to address the issue of post-claims underwriting. It is my hope that legislatures across the country, with your encouragement, will take the following steps to protect consumers and ensure a level playing field in the individual market.

We need to create and adopt a State or National uniform application for individual insurance that is clear, easy for consumers to understand, and takes out some of those trip-ups that do occur in the application.

States must define medical underwriting and be clear that the review of the application alone is not sufficient. Further, States must require that underwriting be complete, and all outstanding questions be asked and answered to satisfaction before the policy is written.

And finally, there should be creation and adoption of laws to stop post-claims underwriting abuses, and provide greater limitations on a company's ability to rescind or limit a policy without a finding of fact and approval of the State regulator.

Since passage of our Connecticut post-claims underwriting law, complaints from consumers have dropped to a handful, and the Insurance Department has received no requests to modify or rescind a policy. I think this speaks to the effect of a good law yet to be tested, but I would encourage my colleagues in other States to join us in ending the practice.

Thank you.

[The prepared statement of Mr. Lembo follows:]

Testimony before the House Committee on Oversight and Government Reform

Kevin P. Lembo, MPA
State Healthcare Advocate
Connecticut

July 17, 2008

Chairman Waxman, Ranking Member Davis and Members of the Committee, for the record my name is Kevin Lembo. I am the Healthcare Advocate for the State of Connecticut. The Office of the Healthcare Advocate is an independent state agency that advocates for and represents consumers in their dealings with the health insurance industry. On behalf of the growing number of Americans who find themselves trying to get and keep coverage in the individual health insurance market, thank you for your willingness to shed light on the problem of post-claims underwriting abuse and insurance policy rescissions.

The problem of post-claims underwriting abuse and policy rescissions appears to be growing. The result of this process, and a particularly egregious result, is the unjust rescission, cancellation or limitation of a health insurance contract after someone is diagnosed with an illness and faced with expensive medical care.

It is important to begin with a clear definition of the problem: I am talking about a health insurance transaction where inadequate underwriting occurs upon a consumer's application for insurance, and an insurance company later mines for a justification in the medical record later for a rationale to rescind the policy. The mining is especially aggressive if an expensive claim stream starts coming through the insurance company's door for payment.

In Connecticut, we were fortunate and identified this problem in our market beginning in 2003. My office, the office of our Attorney General Richard Blumenthal and our state Insurance Department saw a jump in complaints from consumers whose policies were rescinded or limited in some other way. They were sick, and didn't understand why their coverage was taken away or limited. Ultimately, a coordinated and successful effort by our offices was undertaken to fix the problem through legislation.

Connecticut's law, *An Act Concerning Postclaims Underwriting* (Conn. Gen. State. § 38a-477b), is the product of three years of work at the legislature to protect consumers from unfair health insurance rescissions, cancellations or limitations of their individual policies. Under the Connecticut Public Act, insurers now need the approval of the Connecticut Insurance Department before they can rescind, cancel or limit a policy in any manner.

I want to be clear at the outset that this public policy debate is not about consumers who intentionally misrepresent their health status. That is a red herring that is utilized as a distraction for those who rather we not have this conversation. Further, we could spend a day arguing about what motivates the desperate, albeit infrequent, action to lie on an

application. Instead, I am focusing on those whose policies were unjustifiably rescinded, cancelled or limited by a carrier to avoid paying claims.

In Connecticut, a company denied claims for a resident named *Maria* when she was diagnosed with non-Hodgkin's lymphoma in 2005. The insurer said *Maria* should have sought treatment and found out the diagnosis sooner - in other words, before seeking a policy.

Once the company started receiving her medical claims, it found out she had gone to the doctor for what she thought was a pinched nerve. She also told the doctor she'd been feeling a little tired. *Maria* said she wasn't concerned about the way she was feeling because she had been working particularly hard. Tests were done at that time to determine whether there were other issues. These tests did not yield significant results, and were not tests for cancer. The company denied payment for subsequent, cancer-related bills, saying that *Maria* had this condition before she bought her policy and should have sought treatment. *Maria* ultimately died from her illness.

In another case, a company rejected claims of a 34-year-old woman diagnosed with Hodgkin's lymphoma one month after her policy began. Why? In a medical visit after enrolling, she recalled mild shortness of breath while exercising six months before the visit. The insurer said the symptom constituted a pre-existing condition and should have caused her to seek treatment before enrollment. It did not matter to the carrier that the shortness of breath was completely unrelated to the lymphoma and could have been caused by simple over-exertion during exercise.

A young man, *Frank*, was taken by surprise when his insurance was rescinded because his insurer alleged that he omitted material information from his insurance application. When *Frank* applied for coverage, he disclosed that he had occasional headaches. After he applied, the carrier obtained all of *Frank's* medical records – theoretically for medical underwriting – and then wrote him a policy. Several months after getting his policy, *Frank* went for a routine eye exam and was referred to a neurologist by his eye doctor. The neurologist diagnosed *Frank* with Multiple Sclerosis. Immediately following that diagnosis, the carrier rescinded the policy stating, in effect, that he should have known his headaches would have led to the diagnosis of MS. The carrier stuck to its position even after receiving a letter form *Frank's* doctor saying there would have been no reason to suspect MS since *Frank* was an otherwise healthy young man with a normal examination. *Frank* was now responsible for more than $30,000 in care that he could not afford. *Frank's* condition rapidly deteriorated, forcing him to end his employment and seek public insurance and assistance.

These are the kinds of people who are impacted by post-claims underwriting abuses, and that impact is medically and financially devastating.

Unfortunately, while State Insurance Departments can often intercede in these cases through market conduct examinations and under their existing laws against unfair insurance practices, there is little that they can do as regulators to make it right for these consumers. As state regulatory agencies, they can fix problems going forward – making it safe for future consumers, but are limited in what they can do for these now, relatively

uninsurable consumers who are back in the marketplace with new pre-existing conditions that they didn't have before, and a policy rescission in their underwriting history.

States need to stop this problem on the front-end with good, clear law that prohibits these abuses and forces companies to seek permission before rescinding, canceling or limiting an existing insurance contract. The practice must be stopped on the front-end, because the clean-up is almost impossible.

In Connecticut, the Insurance Department recently concluded a very long and deep investigation of the Assurant Companies, Time Insurance Company (formerly Fortis) and John Alden Insurance Company, that resulted in a state record fine of $2.1 million and more than $900k in restitution. The Department did all they could, but the damage to the individuals had been done.

In its review, the Department found that the companies performed unfair or deceptive acts related to denial of payment for claims secondary to the insurance company's false position that the consumers had a pre-existing condition. In addition, the companies were found to have violated various sections of Connecticut's Unfair Insurance Practices laws (Conn. Gen. Stat. § 38a-816) including: failing to process claims fairly or in a timely manner as required by statute; failing to affirm or validate coverage; failing to provide an explanation for claim denials; and, failing to pay interest on late claim payments as required by law.

Although the companies admitted no wrong-doing, they agreed to pay the fine and restitution. In addition, the companies paid for the full cost of the market conduct investigation, and agreed to comply with a corrective action plan that includes annual market conduct exams over the next four years.

In April and May of this year, as part of a larger survey on state health insurance regulation, FamiliesUSA surveyed all state insurance departments regarding laws to prohibit insurers from limiting or rescinding health insurance policies after issuance. FamiliesUSA planned to communicate with the committee directly about the results of their survey, but thought it important to share a few points from their work.

FamiliesUSA put a number of questions to insurance departments across the country, including:

1. Does the state require that insurers complete all medical underwriting and resolve all questions at the time of application?

    a. Thirteen states replied yes: CA, CO, CT, FL, IN, MD, NH, NM, OH, PA, RI, VA, and WA.
    b. Three (AL, NE and OR) replied that while their insurance laws are not explicit, they do enforce such a policy.
    c. States with guaranteed issue and community or modified-community rating (ME, MA, NJ, NY, and VT) generally replied that this question does not apply to them.
    d. The remaining 29 states replied that they have no such requirement.

2. Does state law or regulation require insurers to obtain the state's permission in advance to revoke coverage of individual policyholders due to medical history?

    a. Only Connecticut presently has such a requirement.

3. Does the state give consumers appeal rights if their policy is rescinded?

    a. Nineteen states and the District of Columbia report that they give consumers appeal rights if their policy is rescinded (CA, CT, DC, FL, ID, IL, IN, LA, MD, MN, MO, MT, NE, NV, NM, OR, RI, VT, WA, and WI).
    b. An additional seven states responded that though it is not through a formal appeals process, they investigate consumer complaints if coverage is rescinded (KY, MI, ND, SC, SD, TN, and TX).
    c. In twenty states, consumers do not have appeal rights if their coverage is rescinded.

Mr. Chairman, it is my opinion, and that of many of my colleagues, that our states must move rapidly to address the issue of post-claims underwriting abuses. It is my hope that legislatures across the country, with your encouragement, will take the following steps to protect consumers and ensure a level playing field in the individual health insurance marketplace:

1. Creation and adoption of a state or national uniform application for individual health insurance. This standard application should be created by advocates, academics, and the industry together. It must be clear, and designed to elicit necessary information, but not so heavy with jargon or medical terminology, that the average consumer does not understand the questions or makes errors.
2. States must define "medical underwriting" and be clear that a review of the application alone is not sufficient. Further, states must require that underwriting be complete, and all outstanding questions answered, before a policy is written.
3. Creation and adoption of laws to stop post-claims underwriting abuses, and provide greater limitations on a company's ability to rescind or limit a policy without some finding of fact and approval of the state insurance regulator.

Since passage of our Connecticut post-claims underwriting law, complaints from consumers have dropped to a handful, and the Insurance Department had received no requests to modify or rescind a policy. I think this speaks to the effect of good law and I would encourage my colleagues in other states to join us in ending this practice.

Thank you.

Chairman WAXMAN. I want to thank all of you on this panel. I think it is a panel that made a lot of sense because you are all explaining the problem to us, and you are all advocates of trying to do something about the insurance company practices to take away insurance when people need it the most. It really is astounding. And what you have described, Mr. and Mrs. Bleazard is horrible. When you are sick, that is when you want that insurance coverage to be there, not to have to have insurance companies come in and take it away from you, sticking you with the bill, which I think in your case was $100,000; isn't that right?

Well, people think they get insurance coverage and insurance is insurance. But the reality is that most people have group insurance. And group insurance spreads the risk. The private insurance policies try to avoid the risk. They try to avoid the risk by not insuring people who have been sick. If they have been sick, the insurer won't cover any treatment for that illness. If someone has had cancer, and they apply for a private insurance policy, and they, of course, say they have cancer, because that is part of the questions that are asked, they may be told, well, we will insure you for everything but cancer. Well, that is the business arrangement that can be agreed to. There is no Government requirement to do otherwise, if it is a private insurance policy.

But once they have asked those questions, and all of the information has been furnished, the insurance company can deny coverage of an individual, but if they agree to cover the individual, they shouldn't be coming back afterwards when they get the bills for medical care and say, oh, we are rescinding the policy. And it sounds to me like in many cases it is a trumped-up argument. Is that your experience, Mr. Lembo? You just went through a lot of horrible examples of people who have been denied coverage after they already had the policy and had been paying for it, on trumped-up charges. Is that fair to say?

Mr. LEMBO. Mr. Chairman, in some cases, I think it is fair to say. I think, in the case of the Bleazards, that certainly sounds like what happened. We are looking at a case now that is under investigation, where a person's policy was rescinded as she was in a hospital bed being treated for cancer, but the rescission was based on information, as it was not disclosed, or on hypertension. Under normal circumstances, and without that specter of a large claim coming in, they might has simply limited the coverage to exclude anything related to that hypertension, rather than rescind the whole policy.

Chairman WAXMAN. And tell me again, that in other words, if somebody was denied healthcare coverage and had their policy rescinded because when they put on their application they had occasional headaches that person was supposed to have known that later he would be, or she would be, diagnosed with MS; is that accurate?

Mr. LEMBO. She should have known that it was a large enough problem that she should have sought additional medical attention. As I stated, she didn't think it was that big of a problem.

Chairman WAXMAN. That is really astounding to me. And there are Members of Congress who are not aware of the fact that individual healthcare policies, health insurance policies, are different

than from the group policies. Now, let me just say this to you, and to anybody watching this hearing, if it weren't for a free press, the L.A. Times particularly, doing a series of articles about this issue, I don't know that the State of California officials, and others, would have realized what a problem it was. But when the regulators in California, and in Connecticut, and in Utah, saw what kind of problem it was, these regulators came in and tried to do something to protect people.

We are trying to do this same thing here with this hearing, because there is a Federal law, called HIPAA, that is supposed to stop insurance companies from carrying on these practices. And we are going to hear in the second panel from the Center for Medicare and Medicaid Services. They didn't want to be on with anybody else. They represent the Bush administration. They didn't want to be on a panel with anybody else. We could of had them on with the regulators, but they didn't want that.

Mr. and Mrs. Bleazard, I just can't tell you how pleased I am you would be willing to come and talk about this. This is not a happy situation in your lives to have your insurance coverage canceled on you. You certainly believe you were not treated fairly; isn't that the case?

Mr. BLEAZARD. No, certainly not, you know, we were as honest as we could be. We certainly weren't trying to mislead anybody. You know, we felt all alone, you know, I am surprised that there are other people that are experiencing the same thing.

Chairman WAXMAN. Well, it is clear that your situation was not an isolated incident. We are hearing it from others as well.

Mr. BLEAZARD. At the time, you feel like you are all alone.

Chairman WAXMAN. Yes.

Mr. BLEAZARD. It is you against the world.

Chairman WAXMAN. Yes. Well, this committee is going to open an investigation into the practices of the private health insurance market. We are going to be sending questionnaires and document requests to the major health insurers to get answers to these questions. And I am pleased that all of you are here to give us your perspective.

Mr. DAVIS OF VIRGINIA. Mr. Chairman, I wasn't here earlier. Maybe we can combine the second and third panels. That would certainly be OK with us, just so we could expedite and get the appropriate questions.

I would ask unanimous consent that my opening statement go on the record, so I won't have to read it.

Chairman WAXMAN. Without objection, all opening statements by Members will be put into the record.

Mr. DAVIS OF VIRGINIA. Thank you.

Mrs. Bleazard, let me ask you, obviously the rescission issue in your case is, I think, very disturbing to all of us. On a later panel, the committee is going to hear about a proposal to give individuals in situations like yours, an opportunity to appeal a rescission to an objective panel that includes a doctor and a lawyer, which would have the power to reinstate the policy immediately, so you get an instant appeal to an independent group, including a doctor and a lawyer.

And even if you lose that, you can still sue. So it wouldn't take away your right to sue, if you were to lose that panel. But, what it would allow is, it would give you an independent group to take a look at something like this very, very quickly, because having to go to court is a long—even if you win, you lose, because you have carrying costs, and you are not sometimes getting the care you need in the meantime.

Had that kind of option been available to you and your husband, would you have pursued that understanding that if the panel did rule against you, you could still sue? Would that be something that could be of interest to you?

Ms. BLEAZARD. As I understand it, yes.

Mr. DAVIS OF VIRGINIA. OK. I mean, it obviously devils in the details. I am not trying to trap you. I mean, conceptually, but in an earlier panel, I think you need an instant right of appeal to some independent group in a case like this that can call balls and strikes right off, and sometimes mitigate or solve this earlier on, so you don't have to go to court. If you lose, and you think you got a raw deal, you would still have the right to go to court. That is one of the concepts.

And it would allow you to get, possibly, the opportunity to get your insurance reinstated on an expedited basis. It seems to me that is a reasonable route to go, but we will talk about that a little more. I just wanted to get your reaction to it.

Secretary Bonner, given California's well-publicized problems with rescissions, do you think that the Federal Government should take over enforcement of HIPAA protections?

Mr. BONNER. Well, HIPAA, being a Federal law, I think it would be an inappropriate thing for the Federal Government to be taking a hard look at, yes.

Mr. DAVIS OF VIRGINIA. OK. From the State regulatory perspective, under what circumstances should the Federal Government take over State regulation in the individual insurance market for failure to substantially enforce HIPAA?

Mr. BONNER. Boy, that is, I think, a very difficult question, because I don't think that it is in our interest to have too many carve outs of our State regulatory jurisdiction. As I say, HIPAA, being a Federal law, I think it is a very appropriate thing to be looking at. Beyond that, I am not sure if you are suggesting the State taking over certain aspects of our Knox-Keene or other insurance regulation?

Mr. DAVIS OF VIRGINIA. Well, the problem always is if the Federal Government isn't doing its job, sometimes the State is better off in a State like California, sometimes States don't do the job. I mean, that is always the dilemma in terms of, do you Federalize something like that or give it back to the States? Mr. Lembo, let me ask you, from a State perspective, under what circumstances do you think the Federal Government should step in and take over State enforcement of HIPAA protections?

Mr. LEMBO. Like, Mr. Bonner and Mr. Davis, I would have to say, I am not sure on its face, what those circumstances would be. We would want to preserve the right of States to regulate insurance as they are doing now. I think the Federal Government has a role in encouraging better and stepped-up enhancement.

Mr. DAVIS OF VIRGINIA. Here is my understanding. The individual health insurance market is regulated almost exclusively by States. CMS is responsible for making sure that States enforce protections that are contained in HIPAA. That is the current law. Only if the States fail to enforce HIPAA can the Federal Government take over enforcement and that has not happened.

So I am guessing, with that perspective, from a State perspective, when do you think the Federal Government should step in and take over State enforcement of HIPAA protections? And second, do you think that prior to the recent enactment of State legal reforms in Connecticut, prior to those reforms, was Connecticut failing to substantially enforce HIPAA protections?

Mr. LEMBO. I'll take the second piece first, if you don't mind?

Mr. DAVIS OF VIRGINIA. Yes, you are probably more familiar with that.

Mr. LEMBO. And that is, there was enforcement activity around Connecticut's existing Unfair Insurance Practices Law. Those laws exist in most States, because they are based on an NAIC model that has been adopted by both States, and give the States lots of opportunity to regulate around this issue, without naming it specifically. I think at this point the conversation that happens on an ongoing basis between CMS and the NAIC around ways for those two groups to work together to make sure that there is, in fact, even enforcement seems to be working but could be encouraged.

Mr. DAVIS OF VIRGINIA. Thank you.

Mr. LEMBO. Thank you. Mr. Davis. Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. Mr. and Mrs. Bleazard, I, too, thank you all for being here today, and I am sorry that you are continuing to experience this nightmare. Mr. Bleazard, you and your wife had recently married; is that right?

Mr. BLEAZARD. Yes.

Mr. CUMMINGS. And then you decided that you needed to get both health and life insurance; is that right?

Mr. BLEAZARD. Yes.

Mr. CUMMINGS. And you met with an insurance agent who was fully informed about your health, including your back; is that right?

Mr. BLEAZARD. Yes, they were friends of mine.

Mr. CUMMINGS. And in March 2005, Regence Blue Cross and Blue Shield issued you an insurance policy. Do you remember how much you were paying in premiums?

Mr. BLEAZARD. I think it was in the $300 range.

Mr. CUMMINGS. But you paid them?

Mr. BLEAZARD. Oh, yes.

Mr. CUMMINGS. And Mrs. Bleazard, in October, you had a serious accident, and just hearing your testimony, and so that we reiterate it, you said, "My physicians told me that the fracture is so severe many individuals die as a result of it. The fractures in my back were impact fractures, which shattered the bone at the point of greatest impact. I also had a pulmonary contusion, three broken ribs, and a brain injury. Several hours of neurosurgery were performed to save my spine. I spent 3 weeks in the hospital and in a physical rehabilitation unit, and I am continuing to do physical therapy. My medical bills are over $100,000.00." Is that right?

Ms. BLEAZARD. Yes.

Mr. CUMMINGS. And it is your testimony that the insurance company hadn't paid a dime; is that right?

Ms. BLEAZARD. Well, at first, they paid. And once the bills started mounting, they said they were going to look into it. And then, they took all the money back. And we were left responsible for all of it.

Mr. CUMMINGS. Now, do you have health insurance now?

Ms. BLEAZARD. No.

Mr. CUMMINGS. Are you concerned that you can't or won't be able to get it?

Ms. BLEAZARD. That is correct.

Mr. CUMMINGS. And what impact has this incident had on you, on your family?

Ms. BLEAZARD. Indescribable stress.

Mr. CUMMINGS. And can you tell us a little bit about it? You know what happens so often, I mean, and I was very glad to hear Mr. Bonner's testimony and Mr. Lembo, but what happens too often is that the insurance companies collect, and then when it comes time, when somebody is going through a nightmare, the very thing that they paid insurance for, they then suddenly go AWOL, and individuals like you are left in pain and suffering. And as I listened to Mr. Lembo's testimony, one of the things that I like about the Connecticut system is that they have to have basically preapproval before doing the rescinding; is that right, Mr. Lembo?

Mr. LEMBO. Yes, Mr. Cummings.

Mr. CUMMINGS. And it seems like that system, and then I also am interested to see that in your testimony, Mr. Lembo, you talk about how since the passage of your system, you had very few complaints from consumers; is that right?

Mr. LEMBO. That is correct.

Mr. CUMMINGS. And why do you think that is?

Mr. LEMBO. I think sometimes the best law never has to be enforced.

Mr. CUMMINGS. What do you mean by that?

Mr. LEMBO. Having good law on the books will often put an end to certain behaviors that are questionable, and it never gets to the point where it has to an enforced law, just knowing that the law is there.

Mr. CUMMINGS. And the fact is that when, you know, you think about a person going through the trauma of the Bleazards, or somebody who walks into a doctor's office, and I have often said that we are all one diagnosis from disaster. But they walk into a doctor's office and the doctor says, God forbid, gives them a diagnosis of cancer, they have to have surgery, radiation, chemotherapy, but at the same time they have to tackle a question of whether an insurance company is going to pay. That is a major problem, isn't it?

Mr. LEMBO. It is.

Mr. CUMMINGS. Do you see those kinds of situations, Mr. Bonner, in your experience?

Mr. BONNER. Situations where the insurance company just refuses to pay all of the previously incurred medical bills?

Mr. CUMMINGS. That is correct.

Mr. BONNER. Yes, I mean, you see that is often the case is that sometimes what prompts the review in the first instance is the utilization of services. So it is the big ticket medical bills that sometimes prompts the insurance company to go back and take a look at the application, and then that sometimes results in the decision to rescind.

Mr. CUMMINGS. Now, going back to the Connecticut system, what is your opinion of that system, Mr. Bonner?

Mr. BONNER. Well, we are taking a look at many of the same types of things. We have already developed a model application that is available through the regulatory, through the Department of Managed Health Care, but we are also looking at legislation that might lay out an independent review process, an instant appeal, some of the other preapproval, some of the other things that were referenced in Connecticut.

Mr. CUMMINGS. Thank you, Mr. Bonner.

Chairman WAXMAN. Thank you, Mr. Cummings. Mr. Issa.

Mr. ISSA. Thank you, Mr. Chairman. Mr. Bonner, I am a fellow Californian. I appreciate the good work that you and the Governor are trying to do. As you heard earlier, because we are not able to sort of get our questions and between yourself, the others, and the representative from, if you will, the healthcare industry, I am going to ask you a series of questions. In some cases, they may be obvious, but remember I am going to later be asking the health care industry to comment on some of these same things. For now, I will look at it as a California issue, only because, as a Californian, I am a little more familiar.

First of all, my understanding is in California, the Insurance Commissioner has authority over all insurance, except health care; is that roughly correct? That Insurance Commissioner Poizner has limited jurisdiction in this area?

Mr. BONNER. Well, it is not entirely accurate that he has jurisdiction over health insurance, it is the distinction between regulating the insurance product, which is basically indemnity insurance versus managed care, you know, HMO insurance, which is what the Department of Managed Healthcare regulates.

Mr. ISSA. OK. So, my question would be, do you believe that even if it is joint, that greater jurisdiction to the elected Insurance Commissioner might be helpful in bringing pressure to bear to insure that these kinds of selective abuses don't happen?

Mr. BONNER. You know, I don't see the structure of the regulator itself as being key to the solution here. I think aggressive enforcement and clear rules, and aggressive enforcement of those rules, are really the key.

Mr. ISSA. OK. Well, if I can get to a couple of those potential rules. If, in fact, transferability was an absolute right, meaning that no pre-existing conditions in California could be looked at under any circumstances as long as you were continuously insured, would an absolute statement of that in all 50 States be helpful, to prevent essentially people having to, if there are continuously insured, having to find themselves, you know, going through this process of looking in the rear view mirror, and there is a serious of questions here?

Mr. BONNER. To make sure I understand, you are asking if we just prohibited the practice of rescission, or it would require guaranteed issue?

Mr. ISSA. No, as long someone didn't have a break in insurance when they went from a group insurance to an individual insurance, their background would be prohibited. In other words, if you will, an assigned selection, that if you want to do business in California, you have to accept anyone who is going, let's say, from a COBRA coverage, having left an employer that did have care, to an individual? We would have that right as a condition in California. Would that, in fact, distribute the risks in a way that would be fair but at the same time prevent a huge amount of people having to deal with, in some cases, their pre-existing conditions?

Mr. BONNER. I think, as I understand the question, one of the things that you would be concerned about when you refer to distributing the risks is the scenario where there are substantial numbers of people who in the individual market, in particular, who simply are not in the system. And so, you know, you don't have that same opportunity to share risks or distribute, as you would, in a group environment.

Mr. ISSA. And I want to get to that, but, you know, this is assuming people coming out of a distributive risk. Second, limiting preexisting conditions to ones which are chronic and life threatening, in other words the State could eliminate conditions that are unrelated to the claim from being allowed to cause cancellation of the claim? The State could do that, just yes or no, it is certainly within the power of the State?

Mr. BONNER. The State could do that.

Mr. ISSA. Yes or no, if you don't mind. Is it a good idea?

Mr. BONNER. Yes.

Mr. ISSA. Is it a good idea? You know there have been specific conditions, and Amy may speak to this better, but there are specific conditions where the legislature has made a termination that they are not grounds for cancellation or rescission.

Mr. BONNER. And in this case, an accident. In other words, an event, which is traumatic in its nature. Would that be probably first and foremost among them that even if you knew you had cancer and didn't say so, but you were in a car accident, uninsured, or you were just a rider in the car and you became seriously injured, cancellation, even though you didn't say you had cancer, the injuries are, you know, are unrelated, by definition, wouldn't that be one of the first ones that California should ensure would not allow this retroactive cancellation?

I agree with you that an accident should not be grounds for cancellation, or a recission, yes.

Mr. ISSA. OK. Once again, Mr. and Mrs. Bleazard, you have our deepest, not just sympathy, but recognition that you shouldn't have to be here today. This shouldn't have happened. And I appreciate the chairman's willingness to try to bring focus for change. And I yield back, and thank the chairman.

Chairman WAXMAN. The gentleman's time has expired. Before I recognize the next Member, Members have a lot of conflicts in their schedule, and that is just the way this place operates. And I am going to have to go to a conference committee that I pleaded with

the Senate not to call at the same time, but they didn't pay attention to that. So that is why I wanted to speak out of order.

There has been another request of changing the panels. And Mr. Davis said, perhaps we could put the insurance companies with CMS. Now, I suppose, we could have put everybody on one panel, and we could have moved this hearing faster, but I really don't think that makes sense, because CMS is the regulator. And as the regulator for the Federal Government, they didn't even want to be on a panel with the regulators in the State government, because that would have made some sense.

But to put the insurance companies with CMS doesn't make sense. And you can't have everybody talk all at once. So, we have to have witnesses get a chance to speak and ask questions. So, we have had this panel, which we thought made sense to put you altogether. We have CMS next. And then, we have the insurance companies.

Now, there is a concern on the Republican side of the aisle that people won't be back for the insurance companies. They won't be here for the insurance companies. Well, we only have two Republicans here now, and I hope they will be here, but I don't see Republicans rushing in to be here at all at the moment, but they do have conflicts in their schedule. We have some Democrats, but we don't have all of our Democrats.

So, the Chair's prerogative is to set the agenda, to call the hearings, and to set the agenda, and to, in consultation with the Republicans, establish the order for the witnesses. And I am going to stick with what we have, even though this request has been made because I think what we have makes sense. I will certainly try to be back here for the insurance companies, because I, particularly, want to hear from them and ask them questions.

So, Mr. Davis, I know you have made that request and I hope you will acquiesce.

Mr. DAVIS OF VIRGINIA. Well, you are the chairman. Can we just move ahead? Thank you.

Chairman WAXMAN. OK. Thank you. Mr. Lynch.

Mr. LYNCH. Thank you, Mr. Chairman. And right on point, I am actually in two hearings simultaneously, one down the hall, so I am going to have to leap out and go over to that hearing, and hope to come back in time for the insurance company testimony.

Mr. Chairman, I want to thank you for your willingness to work with the minority, as well. I want to thank the panel for coming forward with their testimony, helping the committee with its work.

Following the chairman's initial remarks, the essence of our insurance system is really to spread risks, to distribute risks across a wider, healthier, less accident prone population. And what has been described here, this practice of post-claims underwriting, basically turns the whole theory of insurance on its head. In other words, the end result here, at least the cases that have been described here, demonstrate a pattern of conduct, and I would say thousands of cases demonstrate a pattern of conduct, by some insurance companies in some States, in which the insurer actually accepts an application for insurance and accepts payment of premiums from the consumer until the point at which a claim is filed.

Then, it appears, at least from the cases we have seen here today, the insurance company rescinds the insurance agreement in many cases based on specious reasoning. The end result is that the consumer is led to rely to his or her detriment on the inducement by the insurance company to rely up to the point that the harm, or the illness, is actually irreparable. Because, but for the insurers inducement, the consumer could have kept on looking for insurance elsewhere, but it was sort of trapped by the insurer's conduct. And again, the number of cases that have been cited here in California, and Connecticut, and elsewhere, indicates that there really is a national pattern of conduct here that is indeed troubling.

Mr. Lembo, you provided a lot of testimony here today, and I want to ask you about a couple of cases that you described. You described a case of a woman who purchased health insurance and then was later diagnosed with Hodgkin's lymphoma, or cancer that attacks the lymph nodes. After she received her diagnosis, her insurer terminated her coverage. Can you tell me why the insurer terminated the coverage in that case?

Mr. LEMBO. Yes, sir. I just have to flip to that one, I am sorry. In the case of the woman with Hodgkin's lymphoma, a 34-year old woman, it was a straight pre-existing condition charge on the part of the insurance companies. They said that she should have sought treatment, because she had experienced minor shortness of breath while exercising.

Mr. LYNCH. Shortness of breath, while exercising?

Mr. LEMBO. That is correct.

Mr. LYNCH. You are serious? OK. Was there any connection between her shortness of breath while exercising and the lymphoma, in your opinion?

Mr. LEMBO. Not being a doctor, I would say, no, but——

Mr. LYNCH. All right. I will let you go on that one. I want to ask you about another example. Some of these are really outrageous. According to your statement, you had a young man in good health. I think you named him Frank. He disclosed to the insurer that he had occasional headaches, that the insurer agreed to issue a policy nevertheless, and then several months later, Frank was diagnosed with Multiple Sclerosis. After learning of that diagnosis, the insurer rescinded Frank's policy. You are more familiar with the detail of this case. Was the rescission in this case justified, in your opinion?

Mr. LEMBO. No, it was not.

Mr. LYNCH. OK. I know that there are tens of thousands of cases cited in California, or in Connecticut, and elsewhere, is it your opinion that this is an isolated practice, or these are outliers, or does this, as I suspect, represent more of a pattern of conduct by perhaps a narrow group of insurers?

Mr. LEMBO. I think that is probably the case, Mr. Lynch, that it is not a common practice, at least not in Connecticut, but the outcome of that process is pretty awful for consumers. So, in a State of $3.4 million, when you get a couple hundred cases of rescission, that is a trend and a spike.

Mr. LYNCH. Mr. Bonner, just the same question on the scope of this——

Mr. CUMMINGS [presiding]. The gentleman's time is up.

Mr. BONNER. Yes, I think that the number of cases we have seen, almost 5,000, or about roughly 4,800, in the last few years, that it suggests that it is a common practice.

Mr. LYNCH. OK. Thank you, Mr. Chairman. I yield back.

Mr. CUMMINGS. Thank you very much. Mr. Bilbray.

Mr. BILBRAY. Mr. Bonner, we heard a lot about this problem in California. And I guess, there is no uniform National policy on reporting rescissions, or whatever. Do you think California is unique in any way, and that is why it seems to have been focused more in California. Or, why is California such a hot bed?

Mr. BONNER. Well, the short answer to your question is I don't think there is anything structurally unique about California, particularly since we are talking about the individual market. And I think part of it obviously is the numbers, you know, it is a large State. And we have almost 3 million, I think roughly 3 million in the individual market, so just the scale and the numbers is, I think, significant. But I would venture to guess that if you just adjust for population and so on that you would find that it is probably a routine.

Many of the same carriers in California are national companies, so those that we mentioned, Kaiser, Health Net, PacifiCare, are national companies, and so, some of these practices are the function of national corporate practice and policy. So, I don't know that there is anything unique to California that would suggest the problem is greater there than other States.

Mr. BILBRAY. Well, if the problem isn't greater there, the problem itself, if you were judging by the complaints themselves, or the highlights of the problem, it goes far beyond our proportionality and population. Is there, you know, is it a heightened sensitivity? Is it the fact that the reporting, or the sensitivity, or the concerns about that, is a little more heightened in California than it may be in the general population of the United States? Because it seems like proportionality in population, even though we are the big guy, we still seem to have more press, more media, more reporting coming out of California than even the numbers would justify. You say you don't think the problem is any worse than anywhere else in the country, do you think the sensitivity to the issue may be what is driving the appearance, at least, of more activity, or more concern, in California based on what we have seen?

Mr. BONNER. I think that maybe a variation on that theme, I would say, rather than sensitivity, I would say awareness, meaning that we have done a lot of work over the last several years to increase consumer awareness of what their rights are, and made it easier for consumers to bring complaints, not necessarily legal complaints, but just complaints with the regulator, and through their health plans.

So, I think all of those things, and in addition to the private litigation that we have seen, the more that you do to shed light on the issue and let people know that they have some form of redress, the more people you are going to have raising the issue, and hence it is much more transparent on the regulatory radar as well.

Mr. BILBRAY. Well, I think the sensitivity to consumer protection in California has been something that, you know, the whole world has talked about before. And, as somebody who has come from a

family lawyer, it also happens to be that California proportionately per capita has more lawyers in any other State in the Union, so, it might raise a little degree there too. But, thank you very much. I appreciate it. And, Mr. Chairman, I yield back.

Mr. CUMMINGS. Thank you very much. Mr. Murphy.

Mr. MURPHY. Thank you very much, Mr. Chairman. I know Chairman Waxman had to go a conference committee, but I would just like to thank him for keeping the order of panels that we have here today.

I am going to go out on a limb and take a guess that the Bleazards don't have a lobbyist, or representative, here in Washington. And I am pretty certain that the families and the individuals that Mr. Lembo talked about don't have lobbyists or representatives, here in Washington.

And I, for one, have absolutely no problem with individual citizens coming to Washington, the stories of individual citizens being told here, being given preference to associations and corporations, who will have every opportunity after this panel is done to reach out to the Members that didn't get to make it to this hearing and make their case. I think that is how hearings should be run. I think we should hear all of the evidence, but I have absolutely no problem with regular, average, everyday people, getting a little bit of preferential treatment in terms of how the stories are being told here, given that they don't have the type of representation that others do.

Mr. Lembo, first of all, I want to thank you for coming. I was in the State legislature for a number of years when the office was created, and have watched it grow, and have watched it become an asset for consumers in Connecticut. And, I guess, my question is this, for all of the States out there that don't have the new statutory structure that we have put in place in Connecticut, what were the tools available to you before this law passed, or to the Insurance Commissioner, when you were receiving these hundreds of phone calls, what was the recourse that you had, or what was the recourse that those individuals had, when they were seeing these rescissions?

Mr. LEMBO. Thank you very much, Mr. Murphy. First of all, I always believe that for every call we get, there are probably 10 that we don't. And I think that is mostly because people don't feel in power to fight that big fight, and also maybe second-guess themselves, did I complete the application appropriately? Is the company right? That said, as I mentioned earlier, there are model laws on unfair insurance practices in most States in the country. They are very useful. In some of our cases, we were able to utilize the pieces of that law to get an appropriate outcome for consumers; but in others, we were not. It wasn't until we had very specific language that we were able to get relief and I hope stop the practice.

Mr. MURPHY. And in many of the cases that you were describing, you were really talking about the insurance companies asking these patients, and these consumers, to be doctors themselves, that they should have known that something was wrong, and should have sought treatment and help before they submitted an application. It is bad enough that we now have insurance companies act-

ing as doctors, and now we are asking the consumers and the clients to be doctors, as well.

And I guess the question is this, what kind of normal medical underwriting would we expect, and this is a question potentially for Mr. Bonner and Ms. Dobberteen as well, would we expect of an insurance company up front when they see an application with a notice of shortness of breath, or back pain, or other specific problems, what is the normal obligation on behalf of that insurance company to go out and do due diligence?

Mr. LEMBO. There is certainly a growing body of agreement around what real medical underwriting is. I think it is fair for a company that is faced with an application that has no flags in it. There are no yeses to any of the medical condition questions. To go forward with that application under certain circumstances. But any, as you mentioned, any of the things that you mentioned should cause the company to then seek the medical record and investigate further.

And once they complete medical underwriting, in the academic sense, medical underwriting, not a shorthand medical underwriting that is just a review of a screening tool, which is what the application is, in a rush to sort of own on a market in a particular State, because it is a lucrative market. If we get there, I think we will see a lessening of this issue, and frankly, the companies will be given an opportunity to fulfil their obligation to their corporate entity, and to their stockholders in some case, to make sure that they are doing their job, as well.

Mr. MURPHY. Mr. Bonner, any comments on the scope of up-front medical underwriting that we really want to be requiring, if we were to proffer a uniform law or encourage States to adopt such laws?

Mr. BONNER. Well, short of a uniform law, or much more detail than what the regulatory requirement is, I think you definitely want to see reasonable inquiry into those issues that may be suggested on the application itself. I think the other thing that is very important is to look at the qualifications of those who are actually doing the review, as well, because one of the issues that we have found is that in many cases the person reviewing the application and the information may not have the necessary qualifications to determine whether they should be making further inquiry to discover a problem. So, we think that there needs to be some very clear rules on what is asked on the application, and very qualified reviewers, as well. Anything you would add to that?

Ms. DOBBERTEEN. Just that new case law in California did add that insurers would be obligated to verify the, not only the accuracy but the veracity of the answers on the application, so that there should be more than just reviewing an application and stamping it OK, that they actually do have the duty of the investigation prior to issuing the policy, rather than post-claims.

Mr. MURPHY. Thank you very much.

Mr. CUMMINGS. Thank you very much, Ms. Speier.

Ms. SPEIER. And thank you to the panelists for being here. I apologize for coming in, and going out, and coming in, but again, a number of hearings are taking place. I want to welcome the regulators from California here. It is great to see you again.

Congressman Bilbray asked a question that I think needs to be explored a little bit more. The question was, you know, is this kind of something more attributed to California than anywhere else where there are more cases? My understanding is that California is unique in the country in that so many Californians are in managed care. The vast majority of Californians, in fact, are in managed care, so they are in group health insurance settings where this would not be an issue. And I would offer that as a question to either of you to answer.

Mr. BONNER. Well, that is certainly true that we have a much greater saturation of managed care in California than you see in other parts of the country.

Ms. SPEIER. So, it would suggest that in areas where there are a larger penetration of individual health insurance, that this is going to be a problem. Obviously, it is a problem in the individual market, not in the group market. So, in States across this country, where individual health plans have a greater penetration, this is conceivably more likely to be a problem?

Mr. BONNER. I think that is a logical assumption to make in the absence of information to the contrary.

Ms. SPEIER. And in your assessment in California, you have identified a number of insurers who have engaged in this practice. Do you have any reason to doubt that it is a practice that is embraced by most insurers, not just in California but across the country?

Mr. BONNER. No, you know, my assumption or, let me back up and say that first, you know, the insurance industry is a very risk adverse industry and very competitive, as well. And what they seek is clear rules, and consistent application in what you see often times, or what I have seen over the years, as both the regulator and now having oversight of the regulator, is that competition in the industry is such that when you have one company that has one approach, or practice, you often see some consistency in that approach and practice among their competitors. And so, I think at least that is what is implicit in your question is, would we tend to believe that the practice is common amongst insurance companies in general, and I would say, it is likely.

Ms. SPEIER. This is a hypothetical, of course, but we are excluding fraud. So, anyone who fills out an application, and fraudulently fills out an application, says that they don't have any pre-existing conditions when, in fact, they did have pre-existing conditions, is not someone we are talking about. We are talking about rescission where it is done unrelated to fraud. Shouldn't we just create a burden on the insurer to establish that, in fact, it is fraud before a rescission can take place?

Mr. BONNER. Well, you may speak to some of the recent case law in California that has moved closer to that result, but you may want to speak to that a little more directly.

Ms. DOBBERTEEN. In fact, California law requires a showing of willful misrepresentation before they can rescind, if they have completed medical underwriting. The new case law did delineate that they have to either absolutely complete medical underwriting in order to rescind, or make a showing of willful misrepresentation. It does require documentation. It does require looking into, rather than just making that assumption.

Ms. SPEIER. So that is case law, but not statutory law?

Ms. DOBBERTEEN. No. It is based on the statute in California.

Ms. SPEIER. All right. So then, it is just an issue of enforcement? If you don't hear about it, you can't enforce it?

Ms. DOBBERTEEN. We have investigated in depth, not just waiting for complaints, but we have investigated all five major health plans who have any products in the individual market.

Mr. CUMMINGS. Thank you very much.

Ms. SPEIER. Thank you.

Mr. CUMMINGS. Mr. Platts.

Mr. PLATTS. Thank you, Mr. Chairman. I will be real brief here. Mr. Lembo, I apologize with coming in late, and I don't think I'm being repetitive, but in your testimony you talked about the issue of intentional misrepresentations, as being more or a red herring issue, can you expound on that? Is that because it is a very small percentage in your opinion and it is blown out of proportion?

Mr. LEMBO. I think it is a very small percentage of the group of folks who have the policy that you are saying.

Mr. PLATTS. What level would you put it at in your opinion?

Mr. LEMBO. You know, not having real data to support that, it is just our experience based on the case work that we do.

Mr. PLATTS. Given the work you do, and seeing that not as a driving issue here apparently by your testimony, is it something that rescissions should not be allowed, or there should be a high bar for a rescission being granted?

Mr. LEMBO. I think before a policy can be rescinded, there needs to be a showing that there was a willful, knowing misrepresentation of health status.

Mr. PLATTS. In Connecticut, what is the standard?

Mr. LEMBO. Knowing.

Mr. PLATTS. Knowing. And your opinion is just that, that should be replicated nationally like that?

Mr. LEMBO. We went for intentional, but lost that particular battle.

Mr. PLATTS. OK. All right. Thank you, Mr. Chairman.

Mr. CUMMINGS. Thank you very much to our witnesses. We would to thank you very much for your testimony to the Bleazards. We thank you. Clearly, I think everyone on both sides are very concerned about what happened to you, and I don't think we want to see that happen to anybody else. And we will do our very best. And I want to thank our other witnesses for providing the testimony. This is the United States of America. We can do better by our citizens. And again, all of your testimony is very helpful. You are now dismissed. Thank you very much.

We will now call on Ms. Abby Block, the Director, Center for Drug and Health Plan Choice, Centers for Medicare and Medicaid Services, here in Washington.

Mr. DAVIS OF VIRGINIA. Mr. Chairman, while she is getting here, let me just note, the reason I want to combine panels is we allowed Mr. Waxman to move the hearing up to 9:30 a.m. this morning. It was inconvenient to us for different reasons, but we allowed him to do that. I had a 12 appointment I couldn't make, and I wanted to get our appointment while I was still here.

It had nothing to do with bringing lobbyists up front. I want to underscore that. There is a proposal that they have, and it would be interesting to have people comment on, but this is not an adversarial hearing. And I think this kind of rhetoric is exactly what is wrong with Congress. Everything has to get torn up into partisanship. We have tried our best to accommodate, you know, the majority with their time. They didn't give appropriate notice for it, but we wanted Mr. Waxman to be able to get his hearing in and be here, because we knew this other committee meeting was called that he couldn't avoid. Thank you.

Mr. CUMMINGS. I want to thank you for your comments. But irrespective of that, I think we can still try to resolve these issues for the people of our great country.

Ms. Block, it is the policy of this committee to swear in all out witnesses. Would you stand and raise your right hand?

[Witness sworn.]

Mr. CUMMINGS. First of all, we are very happy to have you with us. You may proceed.

STATEMENT OF ABBY L. BLOCK, DIRECTOR, CENTER FOR DRUG AND HEALTH PLAN CHOICE, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Ms. BLOCK. Thank you, Mr. Cummings, and our thanks to Chairman Waxman for inviting us today. And thank you Mr. Davis, and distinguished members of the committee for giving us this opportunity to speak. It is my pleasure to be here to discuss the Centers for Medicare and Medicaid Services role in the oversight of individual health insurance markets.

As you know, the agency core mission is administering Medicare, Medicaid, and the State Children's Health Insurance Program. As Director of the Center for Drug and Health Plan Choice within CMS, I oversee day-to-day operations and lead new policy development with respect to individual insurance market issues within the agency's jurisdiction, as well as with respect to private plans in Medicare.

We share the chairman's concern with recent reports that insurers in the individual market might be using rescission as a means for circumventing the guaranteed renewability requirements established in the Health Insurance Portability and Accountability Act of 1996. HIPAA is very clear that, with limited exceptions, an individual insurance policyholder has a right to guaranteed renewability. In other words, an insurer must renew or continue in force an individual's existing coverage unless a specific exception is met. The most relative exception for purposes of today's discussion is if the policyholder acted fraudulently, or made an intentional misrepresentation of a material fact under the terms of the coverage.

CMS believes that States have primary responsibility for enforcement of guaranteed renewability and that CMS can act only if it determines that a State fails to substantially enforce the requirement. Specifically, if a State fails to enact legislation that meets or exceeds Federal HIPAA standards, or if it otherwise fails to substantially enforce the HIPAA standards, the U.S. Department of Health and Human Services has authority to investigate, and if necessary, take over direct enforcement of the standards in that

State. While there is Federal oversight authority, there is no direct Federal role in regulating the private individual insurance market.

It has been suggested that in certain States private insurance issuers might be using rescission, a State contract law concept, to circumvent guaranteed renewability. The role of CMS in addressing such situations hinges on the specific facts of the situation, including any actions already taken by the State. If there is any indication that the rescissions may be occurring for reasons that are inconsistent with the HIPAA guaranteed renewability standards, that would be a red flag that the State may be failing to substantially enforce those standards. CMS could then begin a process, set forth in our regulations, to assess the State's compliance with HIPAA requirements. Depending on the outcome of our investigation, CMS could ultimately take direct control over enforcement of guaranteed renewability in a State.

In light of recent scrutiny of the use of rescission in certain States, the National Association of Insurance Commissioners established a work group in May 2008 to examine and develop recommendations relating to the use of rescission in the individual health insurance market. CMS is actively engaged in this effort, and we applaud the NAIC's leadership on this emerging issue, particularly given HIPAA's clear intent that States take the lead in enforcing individual insurance market protections.

It is CMS's goal to work collaboratively with States and other stakeholders to enforce policyholder protections established by HIPAA. We will do whatever is possible within the scope of our jurisdiction to ensure that States are substantially enforcing HIPAA's protections. Thank you for the opportunity to testify today, and I would be happy to answer any questions you may have.

[The prepared statement of Ms. Block follows:]

STATEMENT OF

ABBY L. BLOCK

DIRECTOR, CENTER FOR DRUG AND HEALTH PLAN CHOICE
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON
RESCISSION OF INDIVIDUAL HEALTH INSURANCE POLICIES

BEFORE THE
HOUSE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

July 17, 2008

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Testimony of Abby L. Block

Director, Center for Drug and Health Plan Choice
Centers for Medicare & Medicaid Services

On
Rescission of Individual Health Insurance Policies

Before the
House Committee on Oversight and Government Reform

July 17, 2008

Good morning Chairman Waxman, Ranking Member Davis, and distinguished members of the Committee. It is my pleasure to be here to discuss the Centers for Medicare & Medicaid Services' (CMS) role in the oversight of individual health insurance markets. As you know, the Agency's core mission is administering Medicare, Medicaid, and the State Children's Health Insurance Program. As Director of the Center for Drug and Health Plan Choice within CMS, I oversee day-to-day operations and lead new policy development with respect to individual insurance market issues within the Agency's jurisdiction as well as with respect to private plans in Medicare.

Let me make clear that we share the Chairman's concern with recent reports that under certain circumstances, insurers in the individual market might be using rescission as a means for circumventing the guaranteed renewability requirements established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA is very clear that, with limited exceptions, an individual insurance policyholder has a right to "guaranteed renewability" – in other words, an insurer must renew or continue in force an individual's existing coverage unless a specific exception is met. Guaranteed

renewability does not apply, for example, if the insurer will no longer offer a policyholder's particular plan in the individual market; if the policyholder moves out of a network plan's service area; or – most relevant to today's discussion – if the policyholder acted fraudulently or made an intentional misrepresentation of a material fact under the terms of the coverage.

CMS believes that States very clearly have primary responsibility for enforcement of guaranteed renewability and that CMS can only act if it determines that a State fails to substantially enforce the requirement. We also believe that the vast majority of States, like the State of California, in fact are enforcing guaranteed renewability appropriately in the individual health insurance market.

We do believe the Federal government has a role to play in ensuring that the consumer protections established by HIPAA, including guaranteed renewability, are being enforced by the States. Specifically, if a State fails to enact legislation that meets or exceeds Federal HIPAA standards, or if it otherwise fails to substantially enforce the HIPAA standards, the U.S. Department of Health and Human Services has authority to investigate, and if necessary, take over direct enforcement of the standards in that State. While there is Federal oversight authority, there is no direct Federal role in regulating the private individual insurance market.

It has been suggested that in certain States private insurance issuers might be using rescission – a state contract law concept – to circumvent guaranteed renewability. The

role of CMS in addressing such situations hinges on the specific facts of the situation, including any actions already taken by the State. With that said, if there is any indication that the rescissions may be occurring for reasons that are inconsistent with the HIPAA guaranteed renewability standards, that would be a red flag that the State may be failing to substantially enforce those standards. CMS could then begin a process, set forth in our regulations, to assess the State's compliance with HIPAA's requirements. Depending on the outcome of our investigation, CMS could ultimately take direct control over enforcement of guaranteed renewability in a State.

To date, CMS has not had reason to exercise this authority in any State. In light of recent scrutiny of the use of rescissions in certain States, the National Association of Insurance Commissioners (NAIC) established a work group in May 2008 to examine and develop recommendations relating to the use of rescission in the individual health insurance market. CMS is actively engaged in this effort, and we applaud the NAIC's leadership on this emerging issue, particularly given HIPAA's clear intent that States take the lead in enforcing individual insurance market protections.

It is CMS' goal to work collaboratively with States and other stakeholders to enforce policyholder protections established by HIPAA for the individual insurance market. We will do whatever is possible within the scope of our jurisdiction to ensure that States are substantially enforcing HIPAA's protections. Thank you for the opportunity to testify today and I would be happy to answer any questions you may have.

Mr. CUMMINGS. I want to thank you very much for your testimony. And let me just ask you, there is a Federal law, the HIPAA Act of 1996 that sets a clear Federal standard that protects policyholders against unfair rescissions, and under that law, your agency is charged with enforcing this minimum standard in ensuring that insurers are not illegally terminating policies; is that correct? Is that what you are testifying to?

Ms. BLOCK. Yes, although HIPAA does not specifically mention rescission, it does mention the discontinuance of coverage.

Mr. CUMMINGS. All right. And the witnesses on our first panel, were you here to hear them?

Ms. BLOCK. Yes, I was.

Mr. CUMMINGS. As a matter of fact, they are sitting right behind you. Describe how insurance companies have engaged in widespread abuses and routinely terminated policies after the policyholder gets a serious illness or injury. The witnesses on the first panel told us that this is very likely a National problem, not one limited to their particular States, and in many States, however, such as Utah, where the Bleazards lost their coverage, there has been no State enforcement. Now, tell me, Ms. Block, has CMS taken any enforcement action with regard to improper rescission practices, any action?

Ms. BLOCK. CMS has not because, remember that, the only time that CMS has any jurisdiction is if a State, if there is any indication that a State is not substantially enforcing the HIPAA provisions.

Mr. CUMMINGS. And how would you know?

Ms. BLOCK. We would have to receive specific complaints to that effect, and we have not received any such complaints.

Mr. CUMMINGS. And so, in other words, a complaint would likely come from someone who felt that they were a victim; is that correct?

Ms. BLOCK. Yes, that would be correct.

Mr. CUMMINGS. And so, you are saying that you have never received any complaints. Is that to your knowledge?

Ms. BLOCK. Not in regard to rescission. Over the last 5 years, we received a total of five complaints about HIPAA compliance, particularly in the State of Missouri——

Mr. CUMMINGS. But in regard to rescission?

Ms. BLOCK. And none of those were in regard to rescission.

Mr. CUMMINGS. I see. Now, one of the reasons your agency hasn't taken any action to protect policyholders is that you have devoted almost no resources to this important responsibility. HIPAA is a big law with numerous enforcement provisions. For example, requirements relating to patient privacy insurance portability standards preventing drive-through births and mental health parity, and all of which need to be enforced. But we were told by the administration, that you all only have four people assigned to the task of enforcing all of HIPAA's provisions, and that is throughout the entire United States of America. Is that right?

Ms. BLOCK. No, I don't believe that is correct, sir. I have four people on my staff specifically that do enforce, have responsibility and jurisdiction over specific HIPAA provisions. HIPAA is, as you say, a very big statute. The Department of Labor has jurisdiction

over some aspects. The Department of the Treasury has jurisdiction. So, I don't represent the whole U.S. Government.

Mr. CUMMINGS. Well, I'm just talking about, with what you testified today with regard to rescission, you all have jurisdiction over that; is that correct?

Ms. BLOCK. That is correct.

Mr. CUMMINGS. You and the four people?

Ms. BLOCK. Yes, I have four dedicated staff.

Mr. CUMMINGS. And they do other things other than the rescission oversight; is that correct?

Ms. BLOCK. They do everything related to the private insurance market.

Mr. CUMMINGS. Very well. Four people for the entire United States of America. Today, we heard appalling stories of truly abusive conduct by insurers who unfairly rescind policies leaving people uninsured and uninsurable in the middle of a medical crisis. Your agency is the ultimate authority of HIPAA's protections and it is your job under the law to make sure that insurers in all States are complying with HIPAA's important safeguards for individual policyholders. How can you possibly enforce all of that with four people?

Ms. BLOCK. We believe that the States have primary responsibility and that our jurisdiction is to ensure that States are, in fact, substantially enforcing the HIPAA provisions. If we have any indication that a State is not doing that, we have the ability through our regulations to investigate and take appropriate action. And I assure you, we will do that.

Mr. CUMMINGS. But that has never happened to your knowledge; is that correct?

Ms. BLOCK. That has not happened.

Mr. CUMMINGS. And when you hear stories like the Bleazards, does that concern you, and does that make you want to go back and do something about it?

Ms. BLOCK. It concerns me very, very much. And, I believe, I have expressed our concern. Obviously, we believe this is a serious issue. We take it very, very seriously. And that is why I look forward to working closely with the NAIC, as they review the problem and come up with solutions.

Mr. CUMMINGS. And what would your solutions be to them, because they are sitting here. They have a $100,000 worth of bills, trying to figure out how they are going to pay them. And by the way, and counting, I mean, what would your solution be? I am just curious.

Ms. BLOCK. I don't have any authority to come up with a solution. I have to act within the jurisdiction that I have under the law and regulations.

Mr. CUMMINGS. Mr. Bilbray. Mr. Murphy.

Mr. MURPHY. Thank you, Ms. Block. Just to explore the Utah situation and law a little bit further. The Federal law, as you have stated, gives you authority to step in when a State doesn't comply with the Federal standard, which is tied to the constitution of fraud, or intentional misrepresentation, and the Utah law, which had jurisdiction in the case of the Bleazards, does not have that same Federal standard of fraud or misrepresentation. In fact, it al-

lows for the insurer to discontinue a policy simply made on material reliance with or without any intentional misrepresentation.

And so, it appears, and I know you may not have had the chance to, you know, take a look at the Utah law, it certainly appears from our reading that there is a clear statutory conflict between the law in Utah that controlled in the case of the Bleazards, and the Federal standard. And so, it would seem, you know, given the fact that we have here today at least one example of a State law, which stands in direct conflict of the Federal law, that maybe a first step might be for the agency to do a review of, and there is only 50 States, so it is probably not that hard to go and take a look at all of the different statutes that control here, and determine which States, by the very definition of their statutory treatment of this issue, aren't in compliance with the Federal law. Does that not seem like a reasonable step to take?

Ms. BLOCK. We actually reviewed all of the State laws right after the enactment of HIPAA to make sure that they were consistent. And it was the determination of the staff at the then-HCFA, that they were, with a few exceptions, the last State that came into compliance was Missouri, which enacted its legislation just recently, in the individual market. What really occurs here is, as I indicated, if there is a situation such as the situation in Utah, and we are very sympathetic to that situation, that could be a red flag. So we would have to look at the specific circumstances of the specific case to determine that in that specific situation, the State is not substantially enforcing the HIPAA provisions. If we were to make such a determination after an investigation, we would then work with the State to make sure that the State came into compliance, which is the ultimate goal, as a very last resort. If the State failed to come into compliance, we could then assume jurisdiction in that State.

Mr. MURPHY. And I appreciate that, but looking at the Utah law, and just to quote you the law, it is unclear to me how on Earth there could have been a determination that this was in compliance. The Utah law says, "No misrepresentation or breach of an affirmative warranty affects the insurer's obligations under the policy, unless the insurer relies on it and it is material, or it is made with the intent to deceive." And so, that or clause allows I think insurers in Utah to cancel a policy based on material reliance.

So, this is just by way of hoping that one of things you will take from this hearing is the chance to go back and re-review the determination that there are 50 States in compliance, because, at the very least, it looks like the Utah policy is not. And last, I understand you haven't received complaints into your office, but don't you think there a pro-active duty on the part of your agency to at least be examining the experience that States have.

It wouldn't take much effort for your agency, I understand you are short-staffed and that is a problem that maybe needs to be solved, but it doesn't seem like it would take much effort to be in contact with someone like Mr. Lembo, or Mr. Bonner, on even an irregular basis. And that kind of contact, that kind of solicitation of input from State regulators and State advocates, would have discovered I think pretty easily, that there was a problem here that

CMS could have stepped in to address. Shouldn't there be some, at least rudimentary, pro-active obligation?

Ms. BLOCK. In fact, that happened, sir. That happens on a regular basis. We talk regularly with State regulators. We meet regularly with them at the quarterly NAIC meetings. That kind of interaction goes on regularly.

Mr. MURPHY. And this didn't come up in any of those discussions?

Ms. BLOCK. Well, it is not that it didn't come up, it is that, remember our jurisdiction kicks in if we have determined or believe that there may be a situation where the State is not substantially enforcing the law, the HIPAA rules. We have no such indication in Connecticut, nor do we have any such indication in California. So, of course, it comes up in discussion, but until, and if, there is a situation where it appears that there may be circumstances where the State is not substantially enforcing the HIPAA requirements, we have no jurisdiction.

Mr. MURPHY. And last, Mr. Chairman——

Mr. CUMMINGS. The gentleman's time is up.

Mr. MURPHY. And last, Mr. Chairman, just to mention, I do think that conflict with State laws would be immediate evidence that a State isn't enforcing the Federal law, and I would just hope that you would go back and take a look at some of these State laws to make sure that your determinations are correct. Thank you.

Mr. CUMMINGS. Ms. Speier.

Ms. SPEIER. Thank you, Mr. Chairman. Ms. Block, we all work for the taxpayers of this country. And they expect us to respond. Now, you have a minimum of $400,000 of taxpayer's funds in four people that are supposed to be doing something to make sure that the laws of the State and the country are being enforced. Now, your comment to us was, well, you saw no problems in Connecticut or California, so you haven't taken any action. Let's talk about some cases that may not have been brought to you specifically, but were brought to you in the media.

In December 2007, USA Today wrote an article in which they talked about a woman's insurance policy being canceled after she had emergency surgery for a perforated ulcer. And it was canceled by her insurer because the only thing that she disclosed on her application was that she was having heavy menstrual periods, a condition her doctor said was normal for a woman her age. So, based on the fact that she was having heavy menstrual periods, her insurer canceled her. It was national media. What action did you take in that case?

Ms. BLOCK. I have no indication that the State had failed to take action. I don't know that the individual had exhausted their State remedies. I can't really act simply on information, which is never full and complete in a news media report. If that case was brought to my attention, I would be happy to look into it and see whether appropriate steps needed to be taken. I don't even know what State that incident occurred in?

Ms. SPEIER. Well, let's talk about another case. This is a case in South Carolina where a policyholder received a $15 million verdict following an illegal rescission. The case disclosed an array of abusive practices. For example, the insurer's computer system was pre-

programmed to trigger automatic fraud investigations based on billing codes. The insurer then rescinded coverage based upon an erroneous date written on a single form. Did you take any action in the South Carolina case?

Ms. BLOCK. With all due respect, ma'am, I do not regulate the individual insurance market.

Ms. SPEIER. No, we understand that, but you do have authority over HIPAA.

Ms. BLOCK. No, the State, apparently, appropriate action was taken in that case. You just said that the person received appropriate compensation.

Ms. SPEIER. Did you contact the South Carolina regulators to determine whether or not they had taken action against insurers in this case?

Ms. BLOCK. It is not my responsibility to do that. It is my responsibility only to determine if, in fact, a State is substantially enforcing HIPAA rules, if a case is brought to my attention.

Ms. SPEIER. With all due respect, if it is in the national media, it is brought to your attention. And, if you do not believe that is brought to your attention if something appears in the national media, then there is about $400,000 we can cut from the budget right now. Thank you, Mr. Chairman.

Mr. CUMMINGS. Thank you very much. Ms. Brock, I just have one question for you. Let me just pick up on what Ms. Speier just asked you. There is an expectation of the people of this country that government is working for them, not against them. And they pay us to solve their problems. And they have one life to live. This is no dress rehearsal and this is their life. And I just have one question for you. If right this second, Mr. and Mrs. Bleazard wrote on a piece of paper, Dear Mrs. Block, we believe that the State of Utah has not done what it is supposed to do in this regard, would that trigger an investigation from you? That is all I want to know.

Ms. BLOCK. That certainly could trigger an investigation.

Mr. CUMMINGS. No, I didn't say could. I said, would it? All we are talking about is an investigation now, I didn't say, conclusion, investigation, because they are sitting here right now and they want to know that their government is working for them. And you just sat here and said you needed a complaint. And I am asking you, these are just regular everyday citizens who paid their premiums, who did everything that they were supposed to do, and they feel like they have been cheated. And I am asking you if right now, if they scribbled on a piece of paper those words, would that trigger an investigation?

Ms. BLOCK. That would certainly trigger my looking into the situation to determine whether the circumstances in that particular case, in fact, triggered an investigation. If they would like to make such a request, I would be very happy, you know, to entertain it.

Mr. CUMMINGS. Very well.

Mr. BILBRAY. Mr. Chairman.

Mr. CUMMINGS. Mr. Bilbray.

Mr. BILBRAY. You know, I don't think that it is appropriate to close this discussion without highlighting the fact that contrary to what a lot of people in this city like to believe, the State and local governments are the front line of protection and service to the peo-

ple of the United States. Washington is not, and has never been meant to be. It is meant to be that we end up, try to be, I agree with you, the last line of defense when systems break down.

But I just have to say it, somebody who comes from almost 20 years of local government service, the biggest frustration I had as a mayor, a county supervisor, as an air resources member trying to protect the public, was the Federal Government always thinking that they were the first line rather than the last line. And we just got to understand that there are always going to be times that we can sit in Washington and second-guess the men and women that are serving the American people on the front line in cities, counties, and States, and always thinking that we could do it better. History has proven that we don't do it better.

Mr. CUMMINGS. I want to thank the gentleman for his statement. With all due respect, let me just say this, and I will be extremely brief, because Mr. Davis has asked me to try and move this hearing along, and I will do that. But, so that we will be clear, Ms. Block, under sworn testimony, said a few moments ago that there were certain things that were under her jurisdiction, No. 1. No. 2, she said that there were certain things that would trigger an investigation of those things under her jurisdiction. That is No. 2.

No. 3, under her jurisdiction, what she has paid for, what she has sworn is her job, I simply wanted to get some answers to a question of a couple that, by the way, at the beginning of our terms, we raise our hands and swear that we are going to protect the American people, I want to make sure that this couple is protected. I am not saying the Federal Government can do it better, or whatever, I am just basing that upon the sworn testimony that was given here this morning.

Ms. Block, I just want to thank you very, very much, and you are now dismissed. Thank you.

Our next witness is Ms. Stephanie W. Kanwit, who is special counsel, to the America's Health Insurance Plans, the trade association for the health insurance industry. Ms. Kanwit, am I pronouncing that correct?

Ms. KANWIT. You are, sir. Kanwit, thank you.

Mr. CUMMINGS. Good.

Ms. KANWIT. Thank you for asking.

Mr. CUMMINGS. She will explain the association's policies. And Ms. Kanwit, I know you just sat down, but I am going to have to ask you to stand up.

[Witness sworn.]

Mr. CUMMINGS. We will now hear from you. And thank you very much for being with us.

STATEMENT OF STEPHANIE KANWIT, SPECIAL COUNSEL, AMERICA'S HEALTH INSURANCE PLANS

Ms. KANWIT. Thank you very much, Mr. Cummings, and members of the committee.

I am Stephanie Kanwit. I am special counsel for America's Health Insurance Plans, and we represent the 1,300 health insurance plans offering coverage to more than 200 million Americans. I heard Chairman Waxman this morning say that one of the pri-

mary issues we are discussing is how to ensure that all Americans have adequate health care coverage. We couldn't agree more.

AHIP, my organization, believes that all Americans should have access to coverage. And I want to tell you very briefly this morning about two of our proposals for reinforming the individual health insurance market, which is what we are talking about.

No. 1, proposals to ensure that no individual falls through the cracks, and No. 2, initiatives to give consumers in this market peace of mind, including new consumer protections with regard to rescissions and pre-existing conditions.

Just very quickly, my paper summarizes what the individual market covers, who is in it. We believe that there are about 18 million people in there. We just took a survey in December 2007, so it is very recent. We found that the individual market is both available and affordable, that 89 percent of applicants who apply and go through the process are offered coverage, and the majority at either standard or preferred rates. But we want to go further.

We have heard some disturbing testimony this morning on rescissions in some very articulate testimony from the Connecticut and California regulators. We know that rescissions are exceedingly rare. Our statistics say that it is two-tenths of 1 percent of policies. Two tenths of 1 percent. We want to make them rarer still. We want to make them extinct.

First, rescission would not be an issue at all if universal coverage existed. So, we have proposed, just recently, a strategy for individual market reform that would guarantee access to health care coverage. That plan would be a public/private cooperative adventure, and it would have States create what we call guaranteed access plans to provide coverage, for those who are uninsured, with the highest medical costs, and our plans correlatively, would do their parts with a coverage safety net, and guarantee coverage to all applicants who aren't eligible for the guaranteed access plans. And there would be capped premiums on that.

Second, and very critically, our Board of Directors, last year, recommended important initiatives to enhance piece of mind to those in the individual market. We have outlined in our testimony in great detail the numerous consumer centric practices we are advocating. And chief among them, and the one that I am most proud of, is the position that legislative drafting, which States can use to enact legislation to provide consumers like the consumers we heard testify this morning, with access to independent third party review, third party review, which would resolve any disputes about medical issues related to not only rescissions, but also pre-existing exclusions.

And our policy, or our proposal, goes even further than Connecticut's, because it would be independent of the health plan, and it would involve both a medical professional and an attorney who is expert in that particular area. And any decision, any decision, and this is critical, would be binding on the health plan.

The other key initiative that we set forth in our testimony are a number of principles. I made them seven separate principles about rescissions. We believe that the health plans have very serious responsibilities. First of all, they should take responsibilities, and you heard this reiterated in some of the testimony this morn-

ing, for conducting a thorough, thorough review of questions asked in an application. And if a plan failed to conduct that thorough review of unclear or questionable information, and failed to seek additional information, then the health plan cannot use that information as a basis for rescinding coverage.

Just quickly, on a final note, we are trying, our association, is trying to come up with policy solutions that work, both immediately and in the long term. Our proposals, which we have detailed in the testimony, take account of State reform efforts over the last 15 years. They were very well intentioned, but we cited a report we just did last year by Milliman, which found that even these well-intentioned State efforts at reform in the individual market, and I am talking about guarantee issue, without a requirement for individual coverage, or community rating, had negative consequences for consumers, higher premiums, decline in enrollment, and often and unfortunately an exodus of health insurers from the market.

I am happy to take any questions this morning.

[The prepared statement of Ms. Kanwit follows:]

Testimony on

Ensuring Fair and Appropriate Practices in Individual Market Rescissions

by

Stephanie Kanwit
Special Counsel
America's Health Insurance Plans

Before the
U.S. House Oversight and Government Reform Committee

July 17, 2008

I. Introduction

Mr. Chairman and members of the Committee, I am Stephanie Kanwit, Special Counsel for America's Health Insurance Plans (AHIP), which is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. AHIP's members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We appreciate this opportunity to testify on issues affecting consumers who purchase health insurance coverage in the individual market, specifically in the very rare case where an insurance policy is withdrawn or "rescinded." We commend the Committee for examining the implications of these issues both for consumers and for the health insurance marketplace.

Our testimony today will focus on proposals AHIP has endorsed for reforming the individual health insurance market through a new strategy that calls for shared responsibility between the public and private sectors. Those proposals include a plan to ensure that no one purchasing coverage through the individual market falls through the cracks, as well as new initiatives designed to give consumers peace of mind about their individual health care coverage. We hope those initiatives will be of interest to the Committee, as they include solutions that directly address the issue of ensuring fair and appropriate practices for rescissions as well as preexisting conditions.

We have worked to ensure that no one falls through the cracks of the U.S. health care system, while recognizing that both the private sector and public programs have a role to play in meeting this challenge. For tens of millions of Americans, the need to repair the health care safety net is a deeply personal issue requiring bold solutions that can be implemented in a timely fashion. We recognize that the current system has shortcomings and we are committed to working with members of Congress to advance meaningful reforms that provide affordable coverage options for all Americans.

Other issues we address in our testimony include survey findings about the current state of the individual health insurance market and research findings on the unintended consequences of enacting certain health insurance reforms in the absence of universal coverage. These findings

provide important insights into the strengths of the current system and lessons learned from state reform initiatives over the past 15 years.

II. Proposed Solutions for Those in the Individual Market

AHIP believes that all Americans should have access to health care coverage, and to that end our Board of Directors has put forth a comprehensive plan to expand access to coverage, including the "uninsurable" and those who can not afford coverage.

To address concerns about the individual market, our Board has endorsed a proposal to ensure that no one falls through the cracks. We offer one strategy for states that are not ready to achieve universal coverage and another strategy for states that establish a requirement for universal participation. We also are proposing new initiatives to give consumers peace of mind about individual health care coverage. As illustrated in the following table, our proposal includes new guarantee issue coverage options, premium caps and subsidies to promote affordable coverage, new consumer protections with respect to both rescissions and preexisting conditions, and new responsibilities for health insurance plans.

The Difference Our Proposal Will Make

New Coverage Options	▪ New program for high-risk individuals ▪ GI coverage for those declined by new program
Premium Rates Capped	▪ New program premiums capped at 150% ▪ GI premiums limited to max of 150%
Premium Subsidies	▪ Sliding-scale subsidies based on income, up to 400% FPL
Insurer Responsibilities	▪ Assist with the application process ▪ GI and assume losses above 150%
Limits on Pre-ex Exclusions	▪ One-time open enrollment with no pre-ex ▪ Third party review for pre-ex decisions
Rescission Protections	▪ Rescinded individuals eligible for new program ▪ Third party review for rescission decisions

A critical element of our proposal provides that health plans should provide consumers with access to an independent, *third-party review process* – established by state legislation – to resolve disputes involving medical issues. That process generally would have state regulators screening requests to determine eligibility for review, would specify timeframes for completing the review (with expedited review available for emergency situations), and would require exhaustion of internal appeal processes before initiating the third-party review as well as exhaustion of third-party review before initiation of litigation. The review panel would consist of (at least) one medical professional and one attorney. Any external review decision favorable to the consumer would be *binding on the health plan.*

State Guarantee Access Plans (GAPs)

AHIP's proposal also would create a new safety net for health care consumers. Specifically, if an individual is unable to purchase individual coverage, or has pre-existing medical conditions, then those individuals with high medical costs would still be eligible for coverage under a state Guarantee Access Plan (GAP). These GAPs are loosely modeled after existing high risk pools and would provide coverage for uninsured individuals with the highest expected medical costs (i.e., those whose claims costs are expected to be 200 percent or more of the statewide average).

If an individual is not eligible for coverage through the GAP, health plans would then provide coverage to that individual on a guarantee issue basis with premiums capped at 150 percent of the standard rate. Our proposal also would make coverage available through the GAP – *without* preexisting condition exclusions – for individuals who maintain continuous coverage or who apply for coverage during a one-time open enrollment period when a GAP is first established.[1]

To keep coverage as affordable as possible, our proposal calls on states to allow health insurance plans to offer features such as pharmacy programs that promote both value and safety; disease management, preventive, and care coordination programs that bring evidence-based care into everyday practice; and new benefit design and payment incentives that reward quality and value. We also encourage states to create a sliding-scale premium subsidy program with additional assistance for those with high health care costs and, additionally, to fund the GAP from a broad base of sources to ensure that coverage remains affordable for those who are currently insured.

[1] This proposal goes further than existing federal law under HIPAA, which requires the guaranteed issue of coverage for those seeking coverage in the individual market under certain conditions, unless those individuals were terminated under their previous coverage for fraud or nonpayment of premiums. 42 U.S.C. § 300gg-41.

Constructing an Individual Mandate for Coverage

AHIP's proposal also recognizes that neither rescissions nor preexisting condition clauses would be an issue if universal coverage existed. Accordingly, our proposal outlines five critical steps that states would need to follow if they seek to achieve universal participation by requiring that every citizen in the state have health care coverage. If a state takes these steps and achieves universal participation, health insurance plans could then *guarantee coverage to all applicants*. While AHIP is not advocating an individual mandate, we have explored this issue and have identified five critical steps that states should take as part of any strategy for achieving universal participation:

- develop an insurance coverage verification system;
- enforce the requirement to purchase and maintain coverage;
- establish an automatic enrollment process and be prepared to provide backstop funding if individuals do not fulfill their responsibility to purchase coverage;
- create a premium subsidy program for moderate- and low-income individuals and families, while also providing additional assistance for those with high health care costs; and
- fund coverage initiatives from a broad base of sources.

The establishment of a universal participation program, based on these steps, could avoid the unintended consequences that have hampered many well-intentioned efforts by states to assist those pursuing coverage in the individual health insurance market.

All of AHIP's initiatives have been developed with the goal of enhancing peace of mind for consumers who purchase coverage in the individual health insurance market and are concerned about having their policies rescinded or having a claim denied under a preexisting condition exclusion in their policies.

AHIP's Consumer-Centric Rescission Principles

Our specific policy proposals are based on a set of seven principles, endorsed by AHIP's Board of Directors, that are the cornerstones of what we believe are the responsibilities of health plans to ensure consumer-centric rescission practices:

1. Clarity in application: In reviewing an application, the health plan should identify any apparently inadequate, unclear, or otherwise questionable information on the application prior to issuing a policy, and should be responsible for obtaining clarification from the consumer prior to issuing a policy.

2. Written underwriting standards: The health plan should rely on written underwriting standards that govern the risk undertaken by the health plan at the time of the application, and should be willing to disclose the reason for an underwriting action to consumers upon request.

3. Information on which rescission is based: The health plan should limit rescission actions to those based only on information that should have been included in a complete and accurate response to questions asked in the application. If the health plan failed to conduct a thorough review of unclear or questionable information from the application process, and, based on that review, failed to seek additional information from the applicant, information subsequently obtained by the health plan may not be used as the basis for rescinding coverage.

4. Prompt investigation: The health plan should undertake a rescission investigation within a reasonable time after obtaining the information prompting the need for an investigation; should make reasonable efforts to obtain, in a timely manner, any additional information needed to complete the investigation; and should complete the investigation within a reasonable time after receipt of or efforts to obtain any necessary additional information. The health plan may not rescind a policy while an investigation is in progress.

5. Procedural steps if there are possible grounds for a rescission: If a health plan, following an investigation, determines that grounds for rescission exist, the plan should:

- notify the customer of the information that has been obtained;
- explain the specific reasons why coverage may be rescinded;
- provide a reasonable time period for the customer to respond with additional information;
- provide clear instructions on how to submit such information; and
- keep the customer apprised of delays because of difficulties in obtaining information.

The plan should promptly review such information, if submitted, and should advise the customer regarding the plan's decision to maintain the policy as issued, reissue the policy subject to revised terms, or proceed with rescission.

6. Evidence must be reliable and preexisting: The health plan's decision to rescind a policy should be based on reliable evidence and should be consistent with the criteria used to initially underwrite the policy. The information on which the health plan seeks to rescind coverage must be material to the risk undertaken by the health plan at the time the policy was underwritten. For example, information about a health condition or treatment arising subsequent to the issuance of the policy may not be used as the basis for, or considered relevant to, a proposed rescission.

7. Need for internal appeal process: Health plans should have a full, fair, and clearly stated internal appeal process, and should clearly inform customers of their right to access the process if they wish to dispute a rescission or a claim denial based on a preexisting medical condition. The process should, at a minimum, include an opportunity to appeal to reviewer(s) distinct from the initial decision maker, and should include review by a medical professional, as appropriate.

III. Background: The Individual Health Insurance Market and Rescissions

To put the issue of rescissions, which is the Committee's focus today, in context, it is helpful to summarize some important facts about who comprises the individual market and what consumers find when they seek to buy individual health coverage.

AHIP published the largest survey of this market in December 2007, and found that individually-purchased health insurance is more affordable and accessible than may be widely known and that it offers a broad array of benefits. AHIP's survey found that consumers in the individual market were offered a wide range of benefits, including mental or behavioral health, prescription drugs, preventive, and maternity benefits. In terms of accessibility, the survey showed that fully 89 percent of applicants who went through the application process were offered coverage in the individual market. Forty percent of these offers were at standard premium rates and 49 percent were offered at lower (preferred) rates.

In terms of affordability, annual premiums nationwide averaged $2,613 for single coverage and $5,799 for family plans in the 2006-2007 period. Since the states are the primary regulators of the individual market, premiums varied by state (as shown in the table below), reflecting a variety of factors, including particular state premium rating and underwriting rules, as well as differences in health care costs and demographics. Premiums were significantly higher in states with "guaranteed issue" and "community rating" requirements that place restrictions on premium variation and underwriting.

Individual Market, Average Annual Premiums by State Single Coverage, 2006-2007	
State	**Average Annual Premium**
MASSACHUSETTS	$8,537
NEW JERSEY	$5,326
NEW YORK	$4,734
RHODE ISLAND	$4,412
PENNSYLVANIA	$3,949
MAINE	$3,686
LOUISIANA	$3,377
NEW HAMPSHIRE	$3,368
NEW MEXICO	$3,362
CONNECTICUT	$3,326
NEVADA	$3,118
NORTH CAROLINA	$3,080

SOUTH CAROLINA	$2,981
FLORIDA	$2,949
SOUTH DAKOTA	$2,914
MONTANA	$2,866
TEXAS	$2,782
WYOMING	$2,688
NATIONAL	**$2,613**
ARIZONA	$2,591
CALIFORNIA	$2,565
WEST VIRGINIA	$2,540
COLORADO	$2,537
KENTUCKY	$2,537
MISSOURI	$2,518
NEBRASKA	$2,505
INDIANA	$2,504
ILLINOIS	$2,499
OHIO	$2,498
MISSISSIPPI	$2,489
OKLAHOMA	$2,435
MINNESOTA	$2,424
GEORGIA	$2,419
KANSAS	$2,363
VIRGINIA	$2,359
DELAWARE	$2,346
NORTH DAKOTA	$2,316
TENNESSEE	$2,221
MARYLAND	$2,208
ALABAMA	$2,208
IOWA	$2,202
ARKANSAS	$2,153
WASHINGTON	$2,015
IDAHO	$2,006
MICHIGAN	$1,878
UTAH	$1,574
OREGON	$1,297
WISCONSIN	$1,254
Source: America's Health Insurance Plans	

Note: Results from Alaska and the District of Columbia, where the responding companies reported fewer than 500 policies in force, are included in the national totals but are not reported separately.

In short, for those Americans who do not receive private health coverage through their employers, the individual market remains affordable and accessible, and we are working to make it even more so. Today, statistics show that over 18 million Americans have coverage in the individual market. To assure them affordable coverage, individual insurance is generally

underwritten, which means employing a process to assess risks and classify them according to their degrees of insurability so that the appropriate rates may be assigned. Without such underwriting, most people who purchase insurance in the individual market would pay considerably more for their health insurance premiums.

The basic principle is that insurance works when there is an average mix of people who are more healthy and people who are less healthy. When individuals wait until they are ill before purchasing health insurance, costs are increased for other policyholders who pay into the system on a regular basis.

In very rare cases, a health insurance contract will be "rescinded," that is, revoked by the insurer.[2] How often does this occur? Statistics show that it is rare, occurring in about two-tenths of one percent of cases. While state law varies, generally an insurer may rescind a policy, at least for an initial period of time after issuance, if the application contained misleading information or omitted information that would have caused the insurer to either not issue the policy or to issue it at a different price or with different terms and conditions.

State law, as noted, heavily regulates insurers' underwriting practices and any rescissions of coverage. The vast majority of states require application forms to be filed and some require specific approval before an insurer can use the application form. In addition, many states regulate the content of the application form. Moreover, states require health insurers to follow certain consumer protection standards when initiating the rescission of an individual policy, and many states have utilized the NAIC Model Law, which AHIP supports, in formulating their rescission-related requirements. The majority of states, for example, require a policy to include a provision prohibiting the use of misstatements, except fraudulent misstatements, to void a policy after two years of the date of issue. In addition, all states require health insurance plans to provide mechanisms for handling grievances and appeals.

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[2] Rescission -- the retroactive termination of a policy -- should be distinguished from "post-claims underwriting," which is the practice of evaluating unclear or questionable information in an insurance application after the policy has been issued. It does not necessarily lead to rescission, but may lead to revised higher premiums, or limitations on coverage. AHIP's Board principles, as noted, discourage post-claims underwriting, and provide that the failure of the health plan to conduct a thorough review at the application stage precludes the health plan from using information subsequently obtained as a basis for rescinding coverage.

IV. Research on Unintended Consequences of Previous State Initiatives

Last year, AHIP commissioned research that yielded important lessons about the unintended consequences that can result when certain health insurance reforms are enacted in the absence of universal coverage. A report by Milliman Inc. examined eight states – Kentucky, Maine, Massachusetts, New Hampshire, New Jersey, New York, Vermont, and Washington – that enacted various forms of "community rating" and "guarantee issue" laws in the 1990s.

The Milliman report found that these initiatives, when enacted without universal coverage, drive up health care costs for consumers, limit access to coverage, and have unintended consequences for healthy persons. The report also found no significant decrease in the uninsured population in states that implemented these initiatives. As a result, several states that initially implemented community rating and guarantee issue laws have since repealed or modified their laws with the intent of stabilizing the insurance marketplace and providing consumers more choice and access to coverage.

These and other findings of the Milliman report are well worth considering in any congressional debate about rescissions or preexisting conditions. The clear lesson for policymakers is that any reforms that give healthy people incentives to delay purchasing coverage will lead to unintended consequences for the broader population. Specifically, it will cause premiums to increase for all policyholders, increasing the likelihood that lower risk individuals choose to leave the market, and thus cause further rate increases. This will ultimately diminish access to high quality, affordable health insurance. Instead of pursuing piecemeal reforms that have been tried before by states and create the unintended consequence of exacerbating existing problems, Congress should consider the challenge of ensuring that individuals with high health care costs receive coverage as part of broader policy changes that would bring meaningful relief to health care consumers.

V. Conclusion

Thank you again for this opportunity to testify. AHIP and our members stand ready to work with you to advance solutions for providing health insurance to the uninsured. We also look forward to participating in a serious debate on the broader challenge of extending coverage to all Americans to ensure that no one falls through the cracks.

Mr. CUMMINGS. Thank you very much for your testimony. Ms. Kanwit, you have heard the testimony earlier; right? Have you been here?

Ms. KANWIT. I did, sir. I have been here all morning.

Mr. CUMMINGS. And probably, all of those insurance companies are part of your association, the ones that you heard mentioned?

Ms. KANWIT. I believe so, yes.

Mr. CUMMINGS. And, as I listen to your testimony, it was quite impressive. And you were talking about things that, you all, would propose. And I am just curious why haven't you all done some of those things? Some of these things, you don't need us. My friends constantly say in the Congress that if they can do it in private industry, let private industry do it.

I have a couple sitting behind you, who is facing $100,000 plus in bills, and counting, after having paid their premiums, and I am sure they are saying, well, that all sounds nice, but what about us? You follow what I am saying?

Ms. KANWIT. I do.

Mr. CUMMINGS. So why haven't your folks done this before? I mean, it sounds good, and it sounds like this is something that has been on the drawing board, most of these things for awhile, or are these things that just came up? When did you all come up with these things?

Ms. KANWIT. Our Board, sir, came up with this last December. We publicized this material last December. And it has been an issue that has been discussed for a while. We are also, as you heard this morning about the NAIC, we are working with them as well on proposals here.

Mr. CUMMINGS. And so, when do you anticipate some of these things to go into effect, because the people who are watching us on television, and I know that you said it is only a very minuscule number of people that may be affected by this, but those people are in pain. Those people are suffering just like this couple is suffering. And we have faces to put with the failure to institute these policies. And I am just curious, when do you anticipate that is going to happen? Or any of them?

Ms. KANWIT. We hope to make again what happened to the Bleazards this morning, for example, a never event. Some of our health plans, for example, have already instituted these policies in terms of the underwriting standards, but we are also working with the State legislatures to implement the issue that I talked about, the third-party review, which would obviate a lot of the problems in this area. It has worked in the medical field, having external review, and this would be third-party review, for rescissions and preexisting conditions.

Mr. CUMMINGS. Now, the reason that the insurer gave for rescinding the policy that the husband Keith had, is that he failed to provide information in the application about his medical issue relating to his back. You heard that testimony? Yet, the relevant section of the application was filled in by Keith's insurance agent, whom Heidi testified had complete knowledge of the medical history. And in any event, the medical history of Keith's back has absolutely nothing to do with Heidi's horrific mountain biking accident, exactly the kind of catastrophic event that health insurance

is supposed, and I am sure you would agree, to protect policyholders against.

And you testified that your industry has new initiatives designed to give consumers peace of mind about their individual health insurance coverage. And I am just curious, why do you think insurers treat people the way that they treated these folks? I mean, I am sure in your discussions, you tried—I mean, in order for you all to get to the recommendations, you had to, I guess, know that these incidents take place. You also needed to know to even come up with that third-party proposal, you had to know that there is some problems here. And so, why is that? Why do you think that is, because they have their opinion, I am sure, but why do you think that is?

Ms. KANWIT. Well, sir, we are trying to fix it. We want to make sure that what happened to them does not happen again in the future. We are asking affirmatively, our member health plans, and our Board supports this, to go back and do thorough up-front underwriting, and if that underwriting is not done, if that investigation is not done, if there is an unclear question, then the health plan cannot rescind based on that information. And I am sure the Chair knows that there are reasons to do underwriting, but you wouldn't need that if we had universal coverage.

Mr. CUMMINGS. And so, you don't think that any of this has anything, I am just curious, I am not trying to put words in your mouth, has anything to do with money?

Ms. KANWIT. I can't speak to that, sir. I can't speak to an individual situation. As a lawyer, I try not to opine in an area where I don't know the facts. I don't know, except what I heard this morning in the testimony, which was very disturbing, I do not know the facts.

Mr. CUMMINGS. All right. Mr. Davis.

Mr. DAVIS OF VIRGINIA. Ms. Kanwit, thank you very much. The facts of the case we heard this morning, that were pretty devastating to whoever was insuring, and I think that is the kind of thing that we don't want happening within the industry. You would agree with that from the facts that were presented here?

Ms. KANWIT. I agree. We are trying to make it never happen again, a never event, as they would say.

Mr. DAVIS OF VIRGINIA. Do you think that the proposed external panel review could mitigate harm done in cases like this?

Ms. KANWIT. Absolutely. I think it absolutely would have. I also want to point out that the Utah couple this morning who testified, had their policy been rescinded under our proposal, they would have gone into the guaranteed access plan that we are supporting very strongly here, where the State and the private plans would get together and assure coverage for every single person, so no one falls between the cracks.

Mr. DAVIS OF VIRGINIA. Look, there are good insurance companies, and there are bad insurance companies, just like good lawyers, bad lawyers, good Congressmen—I mean, whatever, but if you have to take a look at, and I am not going to get into names, but I think in those bad situations, getting some kind of instant appeal to an independent panel is the appropriate resolution quickly. And the difficulties with some of the other things suggested today, we

are just going to put on an army of investigators, and this like doesn't necessarily bring this to any kind of climate, it doesn't bring it to a conclusion.

Additional policing may be part of what we need, maybe, we need to bring CMS into this. That is something we can look at, but ultimately if you are the consumer out there, and you have an injury, and you have a dispute, you don't want to have to go to court. You know, you don't want to have to go on a contingent—nobody gets anything out of that over the short term. And so, that is what intrigues me about this. Now, can this be instituted, it could be instituted voluntarily as part of policies, but do you suggest we do this legislatively?

Ms. KANWIT. We are suggesting that we do this, Mr. Davis, by State legislation, but you are absolutely right, it could be done relatively quickly and expeditiously. And, as I said, it has worked in the medical external review area, and it is a variation of that.

Mr. DAVIS OF VIRGINIA. From an insurer's perspective, is there a difference between rescissions and post-claims underwriting?

Ms. KANWIT. Yes, there is. There are different principles. Post-claims underwriting is a review of the policy after the policy has been issued, which can result in rescissions, but may also result in, for example, additional limitations, pre-existing conditions, or higher premiums. You know, you didn't tell us about your back problem 2 years ago and, therefore we are going to issue the policy, but at a slightly higher rate. So, they are not quite analogous.

Mr. DAVIS OF VIRGINIA. So, post-claims underwriting, you feel is an appropriate industry practice?

Ms. KANWIT. I think it is necessary when you have the individual market that we have now. As I said, AHIP, and our members, and our Board, would like to make it—if you had universal coverage, we would work with the States and the Federal Government to consider how we could do guaranteed issue and you would never need to talk about rescissions, or pre-existing conditions.

Mr. DAVIS OF VIRGINIA. On an earlier panel, Mr. Lembo, you heard him state that associating fraud and rescissions is a red herring, that basically he didn't think there was a lot of fraud in this. There was a small bit of this. Do you agree with that statement, or what has been the experience of the industry?

Ms. KANWIT. I can't speak for the whole industry, but I used to work for one company in the industry. And there is some fraud. People need to be careful, because all consumers are paying for that kind of fraud. And again, with universal coverage, you wouldn't have to worry about that.

Mr. DAVIS OF VIRGINIA. Did some of this originate with the consumer? How about the underwriter? Does it exist there some times, where the underwriter is just interested in selling a policy?

Ms. KANWIT. That could be possible as well, yes.

Mr. DAVIS OF VIRGINIA. It can go up the chain. All right. Well, I am intrigued by this. I hope that we can get more information out on this so that consumers can have some independent appeal in a case like this and not have to hold the court system to do it. And I appreciate your being here today. And I just hope we can get some resolution to these issues.

Mr. ISSA. Just following up on the ranking member's question, when you have an independent insurance agent writing, a bonded agent, would one of the other reforms be that because that is a bonded agent and the insurance company who works with them could seek reimbursement for their wrongful act, would it be reasonable for claims made against failures by that bonded agent to be paid?

In other words, that these two individuals still seated behind you would not find themselves, because of a failure of the bonded agent but rather that person's bond would be where you would seek to get reimbursement. You know, often insurance companies look at themselves as simply a mover of dollars. In their case, it seems like they were a victim of the gentleman's friend, but somebody who failed to do their job properly. How would you comment on that on behalf of, if you will, your industry?

Ms. KANWIT. That could work, but the consumer is responsible for the statements of an agent. But in that particular situation, you could possibly find some recompense there.

Mr. CUMMINGS. The gentleman's time has expired. Mr. Kucinich.

Mr. KUCINICH. Thank you very much for appearing before this committee. In looking at your prepared remarks, I continue to see where you express an interest in making sure that no one falls through the cracks of the health care system. How do you square that with the industry policy of canceling people's health care? I mean, if you are concerned that they don't fall through the cracks, doesn't the industry's policies, basically, push people into the cracks?

Ms. KANWIT. I don't believe so, Mr. Kucinich. One of our problems is that, and this is a serious problem for all of us, have, whatever the number is, 45, 47 million Americans uninsured. We have kind of a patchwork system whereby you heard this morning, Ms. Block testified the States have primary authority to regulate under McCarran-Ferguson, and the Federal Government has some authority.

Mr. KUCINICH. Why do you think people don't have insurance? You are in the insurance business, why do you think it is that people don't have insurance?

Ms. KANWIT. I think that some of it is costs. I think some of it is that people choose not to buy insurance. We all have to work together to get universal coverage.

Mr. KUCINICH. And do you think people don't have insurance because they can't pay for it, that it is unaffordable, that it is not accessible to them?

Ms. KANWIT. Currently, absolutely.

Mr. KUCINICH. The price of insurance is too high; do you think?

Ms. KANWIT. As I said, it is cost as well, and that is what our guarantee——

Mr. KUCINICH. People just can't afford it, I mean, it is too high. The industry charges too much; right?

Ms. KANWIT. Well, the industry charges what it needs to pay out in claims for a system which—the Commonwealth Fund just came out with a report this morning that talked about the number of procedures that are done in the United States, costly procedures that are not medically useful.

Mr. KUCINICH. What is the profit rate of the industry, of private insurers?

Ms. KANWIT. I believe, sir, that it is about 2 percent.

Mr. KUCINICH. Two percent. Does that 2 percent reflect audited figures that relate to their true costs, or does it reflect after paying money for salaries to their executives?

Ms. KANWIT. Those are the profit figures. I can't——

Mr. KUCINICH. Are there people who run health insurance companies who make millions of dollars a year to run those companies?

Ms. KANWIT. I believe some of them do, yes.

Mr. KUCINICH. That is included in the cost of operation; isn't that correct?

Ms. KANWIT. So are all the claims fees, and all of the medical claims, yes.

Mr. KUCINICH. Now, the neurosurgeon in the hospital and the physical rehabilitation unit that delivered this care to Heidi that has been talked about, making it possible for her to resume a normal life, and even travel to Washington to testify, they delivered excellent care, but yet her insurance policy was rescinded and Heidi and Keith don't have the savings to pay $100,000 in medical bills, so the providers are left holding the bag. How does the industry justify treating physicians and hospitals that way?

Ms. KANWIT. Well, I can't speak for the industry or the particular cases. I mentioned to Mr. Cummings I don't know all the facts except what I have heard this morning. We want to make the situations, such as that testimony this morning, not occur again.

Mr. KUCINICH. Should insurers be permitted to tell hospitals individuals are covered, and then later rescind the coverage, and stick the hospital with six figure bills that are likely not to be paid?

Ms. KANWIT. That should not happen and under our proposal would not happen.

Mr. KUCINICH. Now, in northeast Ohio, Mr. Chairman and Ms. Kanwit, Metro Health has been struggling with enormous growth and the cost of uncompensated care. In 2007, they were left with $10 million in bad debt alone, which does not include uncompensated care. This is a huge financial burden on doctors and hospitals, but it happens, you know, to make money for the insurance industry. I want to know how much of this practice of rescission is costing Metro Health and public hospitals like it?

Ms. KANWIT. Probably, very little sir, because rescission is so rare, and 99.99 percent of people do not have their individual policies rescinded. It occurs so infrequently. It is not the bulk of the issues that are a serious problem under uncompensated care. That is a cost-shifting issue that again we have to take care of in the American health care system.

Mr. KUCINICH. Well, I look forward to exploring this further, because we may have uncovered yet another creative but until now virtually invisible way that the insurance industry makes money by denying care. You know, I think, Mr. Chairman, that this industry is the problem not the solution. Other countries have decided to get rid of their for-profit insurance industry and leave the care to patients and doctors without insurance companies intervening, and they have enjoyed great success in providing coverage for ev-

eryone, improving the quality of care, and saving substantial amounts of money.

Mr. CUMMINGS. The gentleman's time is up.

Mr. KUCINICH. I would like to state that H.R. 676 is an important part of that. The U.S. Conference of Mayors supports it, and 91 sponsors in the House. Thank you for being here, Ms. Kanwit. I hope that in the future we can have a not-for-profit health care system, which would make your presence here not necessary. Thank you.

Mr. CUMMINGS. Thank you very much. Mr. Issa.

Mr. ISSA. Thank you, Mr. Chairman. You know, the amazing thing about this committee is that we have virtually no jurisdiction in this area, but we are asserting ourselves, and perhaps the best reason is that if your member companies, and government, and the people fail to resolve this, Mr. Kucinich's bill will become law.

And, it is very clear that we do have to choose between dealing with the 45 to 47 million uninsured, dealing with people who may have pre-existing conditions, but they have to be able to get insured, or they are going to fall not only into personal bankruptcy, but they are going to fall back on to the State anyway.

You know, I, for one, believe that we have a universal health care system. It is the worst possible universal health care system, but what it really says is, everyone will have insurance but that it will be at the emergency room. As a Californian, and I am particularly sensitive to the fact that it is very expensive to deliver that care the wrong way, rather than the right way. On the earlier panel that I had hoped to have you on at the same time, I asked a series of questions and they were probably less tough on the regulators than they will be on you.

The first one would be, why wouldn't it be fair for a State or, if you will, all States to simply assign to every company based on their percentage in the market, cases with pre-existing conditions and essentially, either with or without some participation, financial participation of the State, say this is the cost of doing business?

You know, as you said, there is this two-tenths of 1 percent. If you got only your fair share of all the high risks at a particular company, and everybody took part of that two-tenths, wouldn't we effectively cover pre-existing conditions, get people insured. And the rest of America, or the rest of the State, the 99.8 percent would have a relatively small increase, if assigned risks were part of the scheme. And, I know, you have a proposal for a universal health care, but just dealing with the man and woman behind you, who today have no insurance and, in fact, have a widely exposed pre-existing condition that puts them in the worst possible position in their home State.

Ms. KANWIT. Well, I mentioned, Representative Issa, this morning that we had done this Milliman study that talks about some of the State attempts at reform, all of these well-intentioned reforms, such as guarantee issue, which is what I believe you are referring to right here, that everyone who applied would get insurance. And unfortunately, as I said, the data show that those kinds of reforms raise prices, drive insurers out of the market, and make insurance less rather than more affordable. One of the problems——

Mr. ISSA. But my question was narrow for a reason. As a Californian, one out of every nine people there, now with due respect to the earlier witnesses, that might be true in Utah, if Utah were the only State to do it, but to say that insurance companies will leave California if California were to enact that, let's say, California, Florida, New York, and Texas, I think you would get to a point where you couldn't afford to be in insurance, and more importantly, I accept your statement that you are going to raise prices. But if, in fact, what we are talking about is a fraction of 1 percent, and not all of them, because somebody has hypertension, or has a bad back, or something, not all of them are going to represent large amounts. Some are going to be cancer survivors, who are in remission but find themselves in a very difficult situation, so there will be some.

So my question to you is, looking at it as a National, where would your insurance companies go? They wouldn't go. So, now the question is, how much would that raise the cost? And I would be more than happy to accept an estimate for the record, because I have one or two more quick questions that I need to ask.

And one of them is, what would be the effect if, in fact, State Unemployment Insurance became part of that legacy in that when someone lost their job, they would be covered by the State as part of unemployment, and then would, in fact, come back to you without a gap of insurance? Would that, which is not on the books in any State that I know of, but is part of what Governor Schwarzenegger was trying to do in a comprehensive way, and Congressmen Speier probably knows more about it than I do, having just come from there, would those kinds of things, active from large States, like California, be effective or at least be helpful?

Ms. KANWIT. Your first question about is raising the cost for just this small percentage. But it is not just the small percentage of people, very small, who have their policies rescinded, or canceled, or have pre-existing conditions imposed on them, it is all of how do we get the 47 million, the one out of nine Californians, included in the system, which is why we want coverage for all, and believe that is the way to go to keep prices affordable for everyone by a combination of private and public funding, and our guaranteed access proposal works for that.

On your workman's compensation question, that is a more difficult——

Mr. ISSA. Not workman's comp, unemployment insurance.

Ms. KANWIT. I'm sorry. Oh, unemployment insurance.

Mr. ISSA. Workman's comp should already be——

Mr. CUMMINGS. The gentleman's time is up. I have been very courteous, but I will allow you to answer the question.

Ms. KANWIT. Well, to be honest, I don't know the answer to the question, because you still have, Mr. Issa, the issue of who is going to pay for insurance for some of those folks who are of moderate means? And that is going to be an issue as well. What we have tried try to do with our guaranteed access plan is have the public-private funding there to make sure that they are all covered.

Mr. ISSA. Thank you for your indulgence, Mr. Chairman.

Mr. CUMMINGS. Thank you very much. Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman. Just on the pre-existing condition thing. Right now, there is a lot of employers, I guess, leaving sort of the individual versus group insurance distinction aside for a moment, there is a lot of employers where presumably you have some workers who might have moved on to another job that are staying in the job because of a pre-existing condition and understanding that if they move somewhere else, they may not get that covered. So, the employer that person is staying with, just for the purposes of keeping their insurance in place, is going to face higher costs that drive up the premiums associated with that plan, where if you had a system that was more seamless where people felt they could move without facing this situation related to pre-existing condition, in theory across the board, it would sort of come out in the wash; right? Does that make sense?

Ms. KANWIT. Well, it would be better for everybody. As a matter of fact, our proposal talks, Mr. Sarbanes, about pre-existing conditions, and said, we are recommending a one-time open enrollment plus the third-party review that I talked about with rescissions to apply to pre-existing conditions as well. And by the way, HIPAA provides some protection on that in terms of the portability of your continuous coverage, credible coverage, the continuation of that has made a huge difference in the market.

Mr. SARBANES. Let me ask you again about this distinction between instances where rescission is pursued when there is evidence that somebody fraudulently, or willfully, misrepresented information on their application versus a situation where they just made an innocent mistake, because, I guess, California is a State that requires that there is evidence of willful misrepresentation, or fraud, in order to justify a rescission, but there is other States that do not approach it that way; right?

Ms. KANWIT. Exactly right. Some States have laws that say it can be just a misrepresentation, negligent or otherwise, or omission, whereas a few States say it has to be actual fraud. And, as you heard this morning, California did that with a case called Healy.

Mr. SARBANES. Right. The proposal that the AHIP put forward, you know, as part of these principles, and so forth, where do, you all, stand on that question?

Ms. KANWIT. We are not opining on whether it should be fraudulent or whatever. I mean what we are ultimately hoping is that you don't need rescission at all. We want coverage——

Mr. SARBANES. Why wouldn't you? Why wouldn't you opine on that?

Ms. KANWIT. Well, because you don't need to underwrite, if you have coverage for everyone. If 100 percent of the market is covered, underwriting is never necessary. Underwriting is only necessary when you have a market such as this, which is voluntary, and consumers get to choose, if, and when, they want to buy health insurance. And it really isn't fair to everyone else in the market, and everyone else who has to afford premiums, if a person can find out if he or she needs major medical services, and then decide to buy a health insurance policy.

Mr. SARBANES. But why wouldn't you under the circumstances that currently exist, why wouldn't your association want to encour-

age a practice that only seeks to rescind in circumstances where there is a willful misrepresentation or fraud? Why wouldn't you take that position?

Ms. KANWIT. Well, we might. We just haven't taken that position, because we really don't go there. We figure that is really up to State insurance law to define the situations. We are more interested in the 20,000 foot policy view of how to make it rare or nonexistent.

Mr. SARBANES. Well, I would encourage you to incorporate that into your policy. I don't quite see how the policy can be considered a rigorous one without that component to it. And one of the things that you have talked about is that, you know, one way to pre-empt this situation and rescission, or avoid it, is to do a good thorough review of the initial application; correct?

Ms. KANWIT. Right.

Mr. SARBANES. So that all of the analysis is done there. And I would suggest to you that it is an incentive to do that work on the front-end, if an insurer knows that the only basis for which they can rescind later would be willful misrepresentation, because you would catch the innocent mistakes presumably. Right?

Ms. KANWIT. Right.

Mr. SARBANES. If you were doing a thorough review up-front. So, one of the reasons I am encouraging you to follow the example in the voluntary policy that you are putting forth of States like California, who have made it a requirement that it has to be a willful misrepresentation, as I think that actually encourages the insurers to do the up-front work much more diligently, and in the absence of that policy, they won't be back in the same situation again. Thank you, Mr. Chairman.

Mr. CUMMINGS. Thank you very much. Let me make one correction. Mr. Issa made a statement with regard to the jurisdiction of this committee, and I want to make it clear that under the House rules, this committee has express jurisdiction to conduct oversight over virtually any subject under the legislative jurisdiction of the standing House committees. And I just want to make that very clear. Ms. Speier.

Ms. SPEIER. Thank you, Mr. Chairman. Ms. Kanwit, I was very impressed by your testimony. And you obviously understand the issue of the insured and the importance of trying to make it universal in nature. When I chaired the Senate Insurance Committee in California, we had, from time to time, occasion to engage insurers through their trade associations on issues whether it was health care, or a particular policy that was undertaken by the health insurers that we found to be problematic, but the trade association actually agreed was a problem, and we were able to on a case-by-case basis actually resolve those issues working with the trade association. Is Regence Blue Cross and Blue Shield one of your members?

Ms. KANWIT. Yes, it is.

Ms. SPEIER. All right. I guess I am going to ask you a very specific question then. Having seen it happen in California, and it happened very successfully, I would like to ask you to use your authority and the benefit of your trade association to go back to Regence Blue Cross and Blue Shield on behalf of Mr. and Mrs. Bleazard, be-

cause by your own testimony here this morning, you have indicated that you think that rescission was wrong, and you want to see rescissions become extinct and, clearly, the mountain bike accident that happened to Mrs. Bleazard had nothing to do with that application, and they acted in good faith in filling out that application, and their agent did as well. So I would like to ask you if you would take this case to Regence Blue Cross and attempt to resolve it.

Ms. KANWIT. Absolutely. We will do that.

Ms. SPEIER. I thank you very much.

Chairman WAXMAN [presiding]. Ms. Kanwit, you set out some principles, in fact, seven principles, that you describe as the "cornerstones of what we believe are the responsibilities of health plans to ensure consumer-centric rescission practices." As I understand it, these seven principles were approved by the AHIP Board last November. Can you tell us how many of AHIP's 1,300 members have adopted all seven of these principles? And can you tell us how many are planning to adopt these principles?

Ms. KANWIT. They were adopted by the Board, Mr. Waxman, in December. I don't have figures for you. I would note that of the 1,300 members, many of them, the majority, I would guess, do not even write policies in the individual market, so they wouldn't even be relative to them. Rescission doesn't occur in the group market by and large, because the group market is not underwritten, so they don't even apply. But I don't have an exact figure for you about who has adopted, and who hasn't. I will say that our Board of Directors made up of the presidents of all of our big member companies have adopted these principles and believe that this is the way to go.

Chairman WAXMAN. Well, the reason I asked this question is that judging from their actions, it doesn't seem like all your members are on board. Let's take the rescission of Heidi and Keith Bleazard's coverage. Your principle six States that, "information about a health condition or treatment arising subsequent to the issuance of the policy may not be used as the basis for a proposed rescission," so it is clear to me that the Bleazards' policy was rescinded because Heidi had a serious mountain biking accident that resulted in medical bills in excess of $100,000, and this accident clearly happened subsequent to the issuance of the policy. So under principle six, it can't be the basis of rescinding the policy, yet the policy was rescinded anyway. I thank you very much for your testimony, and helping us deal with this insurance issue, and trying to understand it further.

Ms. KANWIT. Thank you, Mr. Chairman.

Chairman WAXMAN. We have all learned a lot at today's hearing about the abusive practices of some insurance companies, which are dropping coverage for sick people just when they need it the most. We have also discovered that there is much we don't know about the nature of these business practices and the scope of this problem throughout the country. It is important that this committee find answers to these important questions. And so, we will be opening an investigation into the practice of post-claims underwriting by private health insurers. I thank you very much. Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. I will be very brief. I, first of all, want to thank our newest Member, Ms. Speier, for her question. Mr. Chairman, as I sat here, I could not help but look at the Bleazards and the first slight smile that I saw come from them is when Ms. Speier asked the question, would Ms. Kanwit look into their case? And Ms. Kanwit, I just want to follow-up, and I want to thank you Ms. Speier for raising that. I am hoping that you will look into their case and try to help them.

Behind you are sitting two people who are in pain. You can call it 2 percent, you can call it whatever you want to call it, but the fact is that they are Americans who are suffering. And we are concerned about the 2 whatever percent of a percent that you are talking about, because they are the ones that have to pay the bills. They are the ones who have to figure out a way out of no way. They are the ones who have to wake up at 4 a.m., trying to figure out why did they pay the premiums, but yet still when trouble comes, the insurance company is not there.

And so, I know you talked about some things that you all want to do, but I am very pleased to hear that you are going to look into their case. And we are hoping, like you hope, that we won't have to have these hearings in the future, and so that we can address these problems up front, and I want to thank you.

Chairman WAXMAN. Thank you, everyone involved, and I do want to welcome Ms. Speier to her very first meeting of our committee. We are delighted that you are now a member of this committee, and, as I pointed out, you began your tenure as a Member of Congress just a few months ago, but you bring many years of legislative experience to the table from your service as a former counsel to the late Representative Leo Ryan, and from your experience in the California State Legislature, which from my own experience is a good training ground for Congress.

So we are delighted that you are here. Your commitment to improving health care, protecting privacy, looking out for American consumers is certainly going to be an asset to this committee. And I know all Members are looking forward to working with you.

That concludes our hearing for today. And we are going to stand adjourned.

[Whereupon, at 12:15 p.m., the committee was adjourned.]

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